Dissociation and emotions in the context of relationships: A vignette study

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Abstract

A small body of research now exists to support the bi-directional relationship between shame and dissociation. This work has found that when dissociation occurred with a close friend, shame was increased; yet the same result was not evident when dissociation occurred when alone or when with an acquaintance (McKeogh, Dorahy, & Yogeeswaran, 2018). The current studies sought to further clarify the relationship between dissociation and shame, especially the relational context in which dissociation appears to activate shame. Thus the current research examined if elevations in shame were evident following exposure to vignettes describing dissociation in different interpersonal contexts (e.g., old/new therapist, doctor, close friend, alone). Using the narrative scripts developed by McKeogh et al. (2018), participants read stories that depicted either dissociation or sadness, and subsequently responded on measures of emotions, state shame, shame explanations, and behavioural responses. All participants completed the surveys via Qualtrics. For Study 1 (N = 328), analysis suggested that temporary feelings of shame were common responses to dissociation, but did not differ when dissociation occurred with an old and new therapist. There was no significant impact of dissociation on the single-item measure of shame. In Study 2 (N = 245), results show that shame was heightened on the single-item measure following dissociative experiences when with a close friend and doctor compared to when alone. Elevations of shame following experiences of dissociation when with a doctor and close friend appears to suggest that intimacy plays an important role in the relationship between shame and dissociation, and supports the findings of McKeogh et al. (2018).

Introduction

The psychobiological construct of dissociation is commonly understood to involve disruptions and discontinuities in normally integrated functions (e.g., emotions, cognitions, behaviours) that organize an individual's personality (Dorahy et. al., 2017a; Schimmenti, 2016; Platt, Luoma, & Freyd, 2017). According to Nijenhuis and Van der Hart (2011), dissociation divides the personality into two or more parts, which allows the mental subject matter of each to remain comparatively apart and produce dissociative symptoms (e.g., amnesia, flashback). Clinicians have, for over a century, widely discussed dissociation as a reaction to trauma, including the idea that dissociative symptoms (i.e., depersonalisation, derealisation, amnesia) serve to distance the individual from the traumatic experience by protecting them from possible negative affect commonly associated with distressing events (Dalenberg & Carlson, 2012; Platt et al., 2017). Moreover, with trauma being associated with a dissociative division in one's personality, whereby an individual is unable to integrate exposure to adverse events (Nijenhuis & Van der Hart, 2011), not surprisingly, numerous studies have discussed the relationship between dissociation and complex trauma disorders (Dorahy et al., 2015a; Schimmenti & Caretti, 2016; Platt & Freyd, 2015). Findings from this body of research suggest that dissociative symptoms may arise as a response to negative emotions that come out of traumatic events (Schimmenti & Caretti, 2016; Platt & Freyd 2015; Otis, Marchand & Courtois, 2012). According to DeYoung (2015), dissociation acts to shield the self by creating a barrier to experiencing emotional pain. Put differently, dissociative phenomena may act as a mechanism from which one's integrated processes become separated from the self, thus distancing the individual from the affective experience of the

trauma by allowing them to temporarily escape the painful stimuli (Schimmenti, 2016; Dorahy, 2017b).

Although dissociation may facilitate detachment and disengagement from a negative experience, when it becomes a person's default response to excessive stimuli it may hinder their ability to regulate affect. For example, when a neglected or abused child repeatedly relies on dissociation as a means of avoiding emotional pain, their capacity to develop and engage in appropriate affect regulation becomes compromised (Schimmenti & Caretti, 2016; Schimmenti, 2016). Furthermore, DeYoung (2015) argues that dissociative intrusions consist of isolated aspects of the distressing event, which subsequently interferes with a person's ability to accurately integrate and process the trauma into a narrative memory (DeYoung, 2015). The failure to process and integrate the traumatic experience leads to the absence of an internal narrative of the event, which leads to the continued re-experiencing of painful emotions (DeYoung, 2015). A final disruption to a person's functioning caused by dissociation is that of interpersonal relationships, whereby dissociative experiences (i.e., depersonalisation, derealisation) can affect an individual's ability to develop and maintain close relationships by reducing the person's ability to be emotionally present while engaging with others (Dorahy et al., 2015a; Schimmenti, 2016).

There is an abundance of literature that discusses the role of shame as a psychobiological response to traumatic experiences (Thomson & Jaque, 2013; Dorahy et. al., 2017a). A multifaceted emotion, shame is an adverse affect associated with enduring negative experiences of the self, whereby an individual has the perception they are inadequate, flawed or unacceptable (Schoenleber, Sipple, Jakupcak, & Tull, 2015). Given

shame is associated with deficits in the perception of one's identify, and central to complex trauma are alterations in one's self-perception, shame and trauma often co-exist (Platt et al., 2017). Traumatic experiences can threaten one's core-self and lead to feelings of shame (Thomson & Jaque, 2013), whereby the negative impact that shame has on an individual's psychological processes becomes enduring and pervasive (Platt et al., 2017; Scott, 2015). It has also been suggested that traumatic experiences such as neglect and maltreatment can cause feelings of shame through the perception that important interpersonal relationships have failed (Thomson & Jaque, 2013). For example, within traumatized samples, shame has been associated with feeling disconnected in interpersonal relationships (Dorahy, 2010; Dorahy et al., 2015a).

According to Gilbert (2000), shame can be internally or externally oriented, such that an individual's attributes or behaviours are negatively evaluated by one's self or by others respectively. Here, Gilbert (2000) proposes that internal shame arises through negative appraisals of the self (e.g., being weak, feelings of disgust), while external shame occurs when these evaluations are focused on the belief that others would scorn or reject the person. Thus, from a cognitive perspective, internal shame relates to the negative self-directed thoughts a person has about his/her self, including their characteristics and personality, whereas external shame is centred on how one perceives others think of them (Gilbert, 2000; Scott, 2015). Once present, responses to shame manifest in different forms, as illustrated in Nathanson's (1992) 'compass of shame'. He proposes that there are four primary coping strategies to deal with shame: attacking self (self put-down, masochism), attacking others (blaming the victim, lashing out verbally or physically), withdrawal (isolating oneself and hiding), and avoidance (denial, abusing

drugs and alcohol, distraction through thrill seeking). When shame is experienced acutely it can be measured as state shame, whereas an ongoing proneness to shameful experiences can be assessed as trait shame (Dorahy et al., 2017a).

Furthermore, shame is essentially a relational affect; it is a unique and powerful interpersonal response that signals threat to a person's social self (Dorahy et al., 2013). According to DeYoung (2015), shame is intimately connected with being in a relationship with another. She argues that, "shame is an experience of one's felt sense of self disintegrating in relation to a dysregulated other" (p. 22). That is, shame is experienced when one's core-self becomes fragmented due to the 'other' failing to respond with the appropriate emotional understanding that is necessary for the ashamed person (DeYoung, 2015). Given its connection with interpersonal engagement, it is not surprising that when shame is activated in social contexts it can have considerable impact on social functioning, whereby it may evoke withdraw or avoidance behaviours (Dorahy, 2010; Nathanson, 1992).

Given dissociation and shame are common responses to traumatic experiences (Platt et al., 2017; Thomson & Jaque, 2013; Dorahy et al., 2017a), it has been suggested that there is an underlying association between the two constructs. Earlier viewpoints, such as the theory of bypassed shame (Lewis, 1971), argued that a person with high baseline levels of shame was more likely to dissociate, which in turn, would effectively interrupt, bypass, or reduce feelings of shame. Further, Lewis (1992) proposed that a strong emotion such as shame needed to be the mechanism which led to the occurrence of dissociative experiences. More specifically, he suggested that when shame experienced as a result of severe trauma becomes too intense, an individual attempts to remove

themselves from the painful experience through a number of processes, including "extreme forms of dissociation" (Lewis, 1992, p. 172). Perhaps then, pervasive and enduring shame in response to trauma may produce dissociation as a means of alleviating the unwanted negative shame experience. Recent literature on shame and dissociation supports this view, with studies finding that dissociation becomes elevated when shame is induced, possibly as a way to moderate, or even eliminate, the painful experience of shame (Dorahy et al., 2017a).

Therefore, with studies finding that both manifestations of shame and experiences of dissociation are associated with traumatic responses (Bash & Papa, 2014; Platt & Freyd 2015; Thomson & Jaque, 2013), research has begun to examine whether there exists a relationship between dissociation and shame (Dorahy et al., 2017a). To date, research within the context of interpersonal relationships suggests a bi-directional relationship appears to exist between the two constructs (Dorahy et al., 2017a; McKeogh et al., 2018). Broadly speaking, dissociation has been found to heighten following exposure to shame, while experiences of dissociation have also been shown to activate feelings of shame (Platt et al., 2017; Dorahy et al., 2017a; McKeogh et al., 2018). However, there still remains limited understanding as to the purpose and function of dissociation in regards to shame (Platt et al., 2017).

Regarding the bi-directional relationship of dissociation and shame more specifically, the occurrence of dissociative phenomena after exposure to shame appears to be a more robust connection. Research carried out by Dorahy et al. (2017a) found support for shame evoking dissociative experiences. Using both non-clinical and clinical samples, it was found that exposure to shame led to increased experiences of dissociation

irrespective of how it was induced. In contrast, when studied in the opposite direction (i.e., shame being a reaction to dissociation), findings are less conclusive. Specifically, McKeogh et al. (2018) gave participants vignettes where dissociation was occurring in different relationship contexts (i.e., with a close friend, with an acquaintance, when alone), and asked them to respond on shame measures after imagining themselves in each situation. Feelings of shame were higher when dissociating in the presence of a close friend as opposed to when alone or with an acquaintance (McKeogh et al., 2018). Findings from this study indicated that shame was not a common reaction to experiences of dissociation; instead, the shame of dissociation was elicited when in presence of a close friend. A possible explanation for this contextual relationship might be that dissociation was leading to a sense of discontinuity and destabilization when with a close friend, which threatened the breakdown of that relationship and led to feelings of rejection/exclusion, which in turn activated shame (McKeogh et al., 2018). Thus, dissociation may have provided a greater risk of exclusion when with a close friend as opposed to when alone or when with an acquaintance, which then resulted in shame being elevated. Schultz (2018) provided additional support for dissociation activating shame by finding that acute experiences of dissociation heightened state shame in 28 adult survivors of childhood sexual abuse. Moreover, using a sample of female trauma survivors to examine whether dissociation functions as a means of bypassing shame (Lewis 1971), Platt et al. 2017 found that elevations in dissociation instead produced increased levels of state shame. Taken together, a small body of literature now exists on there being a bi-directional relationship between dissociation and shame: shame seems to

heighten dissociation and dissociation appears to heighten shame, at least in more relationally connected contexts and within trauma samples.

Whilst promising, there currently exists no clear explanation regarding what the underlying mechanisms of dissociation are that evoke feelings of shame. McKeogh et al. (2018) hypothesized that perhaps the shame-inducing elements of dissociation are related to having a sense of not being unable to control one's awareness and consciousness, and feeling a loss of connection with someone whom a bond is shared with. Further, it may be that, when in the presence of a close other, experiences of dissociation are accountable for increased feelings of social exclusion and isolation, and having fear about rejection/exclusion (McKeogh et al., 2018). Thus feeling socially excluded by close others might automatically bring forth shame. Given that social exclusion may be largely accountable for the activation of shame, and that the progression of intimate relationships appear to be threatened by experiences of dissociation, "dissociation might have the capacity to act as a natural 'shamer' when occurring with close others" (McKeogh et al., 2018, p. 53). Schultz (2018) suggested that those who dissociated in relationships reported that a sense of feeling flawed and exposed led to shame feelings.

Study 1.

Study 1 attempted to replicate findings from research carried out by McKeogh et al. (2018), but examined whether the same results were found in a context more relevant to the clinical setting: when with a new and old therapist (as opposed to a close friend and acquaintance). Further, Study 1 sought to identify what aspects of dissociation are associated with elevations of shame. The present study had two objectives. First, to further examine the direct causal link between dissociation and shame. Second, to assess

whether experiences of dissociation heighten feelings of shame across different relationship contexts as opposed to when alone. In addition, the current study sought to investigate the underlying causal mechanisms of dissociation that give rise to shame, especially when intimacy increases. Regarding the study's first objective, it was hypothesised that shame would increase following experiences of dissociation. For the second objective, it was predicted that dissociative experiences would elevate feelings of shame when in the presence of a close other (i.e., old therapist), compared to when with a new therapist or alone. Regarding the mechanisms of dissociation that give rise to shame, consistent with the tentative idea noted in recent work (McKeogh et al., 2018; Schultz, 2018), it was hypothesised that exclusion, loss of control, feeling isolated, fearing rejection, and being judged negatively would be related to elevated shame in those who dissociate. Additionally, it was predicted that explanations such as feeling flawed and exposed for having the experience would increase when experiencing dissociation (as opposed to sadness) in the presence of a close other.

Method

Participants

The sample size of the current study was based on McKeogh et al. (2018), who had a final sample of 269 participants after losing approximately 20% of respondents during data clean up. Study 1 aimed to recruit a larger participant pool with the expectation of losing a high number of responses due to the addition of another validity check.

Four hundred and twenty one participants started the survey, however, 93 had to be excluded because they either completed the survey in a time period not considered possible for accurate responding (i.e., under five minutes), stopped before completing the survey or failed the two validity checks. The majority of the discarded participants were

male (n = 65; 69.9%); the mean age of the excluded sample was 30.40 years (SD = 8.61). ANOVA showed significant differences existed in the distribution of age between the included and excluded sample, $F(1, 419) = 14.08$, $p < .001$, $\eta^2_p = .03$. Likewise, Chi Square tests revealed significant differences in the distribution of gender between the included and excluded sample, $\chi^2 (1, N = 328), = 10.88$, $p < .001$. The 328 participants left in the final sample aged between 18 – 60 years (M = 35.07; SD = 11.09). The sample was equally divided between male (n = 166; 50.6%), and female (n = 162; 49.4%). The majority of the participants stated that they were American citizens (n = 310; 95.1%), leaving 16 (4.9%) who were non-American citizens and coming from countries such as India, Venezuela, and Colombia. Regarding ethnicity for those in the final analysis, the majority of participants reported their ethnicity to be White/Caucasian American (n = 259; 79%), whereas 29 (8.8%) identified as Hispanic American and 18 (5.5%) identified as African American. The remainder of the participants (n = 22; 6.6%) identified as either Asian American (n = 14; 4.3%), Native American (n = 4; 1.2%), Multiracial (n = 2; .5%), or Other (n = 2; .5%). Two participants did not complete this question. More than half of the participants were married (n = 139; 42.4%), 119 were single (36.3%), 67 were in a relationship (20.4%), 2 were separated (.6%), while 1 was widowed (.3%). Almost half (n=148; 45.1%) of the participants had completed a Bachelor's degree, while 63 (19.2%) were completing a course or diploma. Other levels of education included completing High School (n = 48; 14.6%), having a Master's degree (n = 47; 14.3%), completed a Ph.D. (n = 8; 2.4%), 'other' (n =10; 2.4%), and leaving High School before finishing (n = 4; 1.2%).

Seventy-three participants in the final sample described being diagnosed with a psychological illness (22.3%; the figure was *n* = 14 or 15.1% in the excluded sample). The final sample included participants reporting anxiety (*n* = 45; 13.7%), mood disorders (*n* = 35; 10.7%), post-traumatic stress disorder (*n* = 10; 3%), attention deficit hyperactivity disorder (*n = 8;* 2.4%), eating disorder (*n = 5;* 1.5%), personality disorder (*n = 48;* 21.2%), substance use disorder (*n* =3; .9%), having either schizophrenia, obsessive-compulsive disorder, or a dissociative disorder (*n* = 2; .6%), and either dissociative identity disorder (*n* = 1; .3%) or autism (*n* = 1; .3%). A total of 85 participants (25.9%) indicated that they had seen a therapist for a mental illness difficulty, of which 20 (6.1%) indicated that they were currently seeing one. One participant did not complete this question. When responding to time spent in therapy, 7 participants (2.1%) reported spending more than two years attending therapy, four (1.2%) stated being in therapy between one and two years, 2 (.6%) reported being in therapy for less than 6 months or between one and three months, 1 participant (.3%) stated being in therapy between 3 and 6 months.

Measures

Demographics. In addition to answering brief demographic questions (gender, age, relationship status, ethnicity, nationality, and highest qualification), participants were asked whether they had ever been diagnosed with any mental health difficulty. If upon answering 'yes', participants were then asked to indicate which disorder(s) applied to them. Finally, participants were asked if they had ever seen a therapist for a mental health difficulty (yes/no) and if they were currently in therapy (yes/no). Similar to before, if participants responded with 'yes' to the latter question (i.e., currently being in therapy),

they were then asked to indicate the length of time they had been seeing a therapist. Participants read and completed all of the questionnaires online via Qualtrics survey software.

Trait Dissociation. The Detachment and Compartmentalisation Inventory (DCI), which consists of 22 self-report items, is a newly developed scale that measures detachment and compartmentalisation (Butler, 2017) (see Appendix C). Participants respond to items from 0 (never) to 7 (daily) and excluding experiences that only happen under the influence of alcohol or drugs. To ensure valid responding, items 5 and 20 of the DCI act as validity control items. The DCI demonstrates strong psychometric properties, including good internal reliability, and convergent and construct validity (e.g., 0.97) (Butler, 2017).

Trait Shame. The Experience of Shame Scale (ESS) was used to measure trait shame (see Appendix D). Using a 4-point scale ranging from 1 ('not at all') to 4 ('very much'), this self-report scale consists of 25-items (Andrews, Qian, & Valentine, 2002). To ensure valid responding, a validity control question was added near the middle of the ESS which read, 'If you have read this question, please indicate not at all' (item 17). The ESS measures shame in three separate areas: characterological shame (12 items, e.g., avoided people because of your manner), behavioural shame (9 items; e.g., ashamed when you said something stupid), and bodily shame (4 items; e.g., ashamed of your body or any part of it). Research shows the ESS has strong psychometric properties, with a Cronbach's alpha of .92 (e.g., Duran & Lewis, 2012; Andrews et al., 2002).

Experimental stimuli

Vignettes. The vignettes used in the current research were based on McKeogh et al. (2018), with changes mainly pertaining to different relationship contexts (e.g., rather than close friend as seen in McKeogh et al., 2018, Study 1 used old therapist). Whilst similar to McKeogh et al. (2018), to ensure understanding and flow between the narratives and measures of shame, the vignettes were nonetheless piloted on 10 post-graduate psychology students.

Study 1 utilized two independent variables, one called 'experience' which assessed dissociation and sadness experiences, one called 'relationship context' that assessed experiences when with a new therapist, old therapist, or alone. In order to capture the two independent variables (experience, relationship contexts), 18 vignettes were developed. The 'experience' variable was separated into dissociation and sadness (control condition), whereby both were further divided into three levels. For example, the 'experience' of dissociation was captured by having a flashback, experiencing amnesia and experiencing depersonalisation. It was felt these symptoms of dissociation best captured the different manifestations of dissociative experiences and ensured participants had adequate coverage of the variable (Platt & Freyd, 2015; McKeogh et al., 2018). For the control condition, sobbing, feeling heavy and being gloomy represented the three comparative sadness experiences. Similarly, the second independent variable 'relationship context' was also divided into being with an old therapist (i.e., someone you have been seeing for a long time), being with a new therapist (i.e., someone you have had two previous sessions with) and being alone. The 'experience' (dissociation - flashback, amnesia, depersonalisation/derealization versus sadness - sobbing, heavy, gloomy) and

'relationship context' (old therapist, new therapist, alone) independent variables were merged such that dissociation and sadness were experienced in each relationship context (e.g., experiencing flashback while being 1) with an old therapist, 2) a new therapist and 3) alone. This led to a total of 18 vignettes being developed, whereby nine reflected dissociation in each relationship context and nine reflected sadness in each relationship context (see Appendix E).

For the 'experience' independent variable, the flashback condition had the person losing contact with their surroundings and being transported back to an earlier traumatic experience; the amnesia condition had the person feeling disorientated and experiencing a feeling of drifting off such that when they 'returned,' they were not aware of what had been happening and why they were sitting in a different position in the chair; and in the depersonalisation/derealization condition, the person experienced detachment from their body (depersonalisation) and feeling as though the new/old therapist was a long way away (derealisation). Regarding the comparison vignettes, the dissociation content in each of the three relationship contexts were replaced with material the same length that reflected sadness-related experiences. Both the sobbing condition (i.e., tears rolling down the person's face) and the gloomy condition (i.e., feeling gloomy and down) spoke about feeling this way when remembering a recent occurrence, while the heavy condition spoke of a heavy feeling in the person's body upon remembering people who have drifted away. For the relationship context, the alone context involved being home alone reading a book, the old therapist context involved seeing a long-term therapist and talking about a recent experience, and the new therapist context involved meeting up with a therapist who had only been seen twice before and discussing current problems.

The vignettes were written in second person narratives (e.g., 'you become upset about something that happened to you recently') in order to heighten their self-referential nature. Within all the vignettes, certain words and phrases were bolded to further emphasize the dissociation or sadness experience being reported.

Measures of shame

Three measures were used to assess whether shame was being evoked upon reading both the dissociation and sadness vignettes. The first assessed 8 separate emotions via individual questions (e.g., 'Would you feel': Angry? Ashamed/Embarrassed? Sad? Surprised? Guilty?). Immediately after reading each vignette, participants rated their feelings using a 5-point scale from 0 (not at all) to 4 (extremely). Shame and embarrassment were treated as a single emotion and response in the final analysis as they are considered to both belong to the same affect family (Tomkins, 2008; Nathanson, 1992). Participants who rated themselves anywhere between 1 (a little) and 4 (extremely) for the shame emotion were then asked to further rate their response using seven shame explanations. More specifically, participants were asked to respond why they felt ashamed/embarrassed after reading the vignette (i.e., feeling exposed or flawed, as though they had lost control over themselves, isolated/excluded from what is happening inside them, isolated/excluded from what is happening around them, feeling badly if others knew what they were experiencing, and feeling judged/rejected if someone was to see them in this way. Participants rated their reasons for feeling ashamed upon having the experience using an identical 5-point scale of 0 (not at all) to 4 (extremely) (see Appendix F).

The second measure to elicit if shame was present was the 5-item state shame subscale from the State Shame and Guilt Scale (SSGS, Marshall, Sanftner, & Tangney, 1994). The wording of the phrases on the original shame subscale were slightly adapted by taking the word 'I' off the beginning of each sentence ("I feel worthless, powerless") and instead creating a question at the start of each statement. For example, "would you feel worthless, powerless." Using a 5-point scale, participants rated how much they would feel each of the five shame items from 'not at all' to 'very strongly' (see Appendix F).

Drawing in part on Nathanson's (1992) Compass of Shame, the final measure developed for the study assessed 7 behavioural responses to shame (e.g., withdraw, attack self and attack other). For both the new/old therapists contexts, the 7 behavioural responses were: talk to your new/old therapist about it, quickly leave the room to get away from your new/old therapist, hide your head in your hands or divert your gaze from your new/old therapist, get annoyed with yourself for having this experience in the presence of your new/old therapist, distract attention away from what happened and talk to your new/old therapist about something else, get frustrated with your new/old therapist for being with you, and sit calmly with your new/old therapist. The alone context contained the same 7 behavioural responses but was designed to reflect having the experience when alone (e.g., quickly leave the room where it occurred, get annoyed with yourself for having this experience). Again using a 5-point scale from 0 (never) to 4 (definitely), respondents rated how much they would engage in each of the behavioural responses (see Appendix F).

Procedure

The study was approved by the University of Canterbury Human Ethics Committee prior to the commencement of data collection. Participants were recruited using the online crowdsourcing platform, CrowdFlower (Peer, Samat, Brandimarte, & Acquisti, 2017). Questionnaires were completed on a personal computer via Qualtrics software, prior to which participants read the information (see Appendix A) and consent form (see Appendix B), and completed the demographic questions pertaining to mental health difficulties. Following on from this, the DCI and the ESS were randomly administered, which was followed by being randomly assigned to one of six conditions: alone-dissociation, old therapist-dissociation, new therapist-dissociation, alone-sadness, old therapist-sadness, and new therapist-sadness. Each of these conditions contained three vignettes that reflected either different dissociative experiences (depersonalisation/derealisation, flashback and amnesia), or comparison experiences (sob, gloomy and heavy). Once participants had read their three vignettes they responded to shame measures and when finished, were given a unique code to redeem their $1.50 credit. Finally, two web addresses offering support were provided for participants in the case of them experiencing any distress during their involvement in the study.

Design and analysis

Given the complexity of the analysis and to facilitate its interpretation, the three dissociation groups (i.e., flashback, amnesia, depersonalisation/derealisation) and the three sadness groups (i.e., sob, heavy, gloomy) were collapsed to form single experiences of both dissociation and sadness. Thus, the primary analysis was a 2 (Experience: dissociation, sadness) by 3 (Relationship Context: new therapist, old therapist, alone)

between-subject design, where the main effect for 'experience' assessed the first hypothesis and the interaction effect assessed the second hypothesis. The dependent variables were: (1) 8 separate self-report emotions (i.e., anger, ashamed/embarrassed, relaxed/calm) assessed by Multivariate Analysis of Variance (MANOVA), (2) 7 shame explanations (i.e., feel flawed, exposed, judged) assessed by MANOVA, (3) the state shame scale assessed by univariate analysis of variance (ANOVA), and (4) the behavioural responses (i.e., talk, leave, hide) assessed by MANOVA. Pillai's trace statistics was interpreted for MANOVA results while Gabriel's was used for post-hoc assessments as sample sizes were unequal (Field, 2013). The statistical programme Statistical Package for Social Science (IBM SPSS Statistics 25) was used to gather and code all data. Exploratory analyses were conducted following reliability and descriptive statistics, and outliers adjusted accordingly.

Results

Characteristics. Regarding currently seeing a therapist, in terms of the single-item emotions, there was no significant multivariate effect for those currently seeing a therapist vs. those not, $V = .04$, $F(8, 319) = 1.86$, $p = .07$, $\eta^2_p = .04$. In addition, there was no significant multivariate effect for those currently seeing a therapist vs. those not for the 6 behavioural responses, $V = .32$, $F(7, 320) = 1.53$, $p = .12$, $\eta^2_p = .03$. However, a main effect was found for the 20 participants currently in therapy on the state shame measure, $F(1, 326) = 13.30$, $p = <.001$, $\eta^2_p = .04$. Those participants currently in therapy scored higher on measures of state shame following the induction. However, Chi Square tests revealed no difference in the distribution across both Experience (dissociation, sadness), $\chi^2 (1) = .00$, $p = 1.00$, V = .00, or Relationship Context (alone, new therapist,

old therapist), χ^2 (2) = 4.30, p = .12, V = .12, for those currently in therapy compared to those not (See Appendix G).

Regarding the 85 participants who reported having ever seen a therapist, there was a significant difference across Relationship Contexts, χ^2 (2) = 5.94, p = .05, V = .12. Further analysis showed that there were significantly more people who had previously seen a therapist compared to those who had not in the new therapist group compared to the old therapist group, χ^2 (1) = 4.22, p = .04, V = .14. The same was true for those in the new therapist context as opposed to the alone context, χ^2 (1) = 4.21, p = .04, V = .14. In contrast, when comparing the old therapist and alone contexts, there was no significant difference for whether participants had ever seen a therapist compared to having not, χ^2 (1) = .00, p = .95, V = .00. In terms of the 8 single-item emotions, a significant multivariate main effect was found when comparing the 85 participants who had ever seen a therapist to those who had not, V = .07, F(8, 318) = 2.97, p = .01, η^2_p = .07. Univariate analysis showed higher ratings in those who had ever been to a therapist for angry, F(1, 325) = 9.32, p = .002, η^2_p = .03, shame, F(1, 325) = 7.71, p = .01, η^2_p = .02, sad, F(1, 325) = 10.76, p = .001, η^2_p = .11, anxious, F(1, 325) = 9.79, p = .002, η^2_p = .03, guilty, F(1, 325) = 4.04, p = .05, η^2_p = .01, and proud, F(1, 325) = 4.33, p = .04, η^2_p = .01. This indicates, that for the participants who reported having ever seen a therapist, they felt more shame, feelings of anxiety, guilt and sadness, but also proud compared to those who had never seen a therapist. Similarly, a significant multivariate main effect was found for the six behavioural responses when comparing those reporting ever having seen a therapist to those who had not, V = .06, F(7, 319) = 2.82, p = .01, η^2_p = .06. Univariate analysis showed higher ratings in those having seen a therapist for leave, F(1, 325) =

1.45, p = .05, η^2_p = .01, hide, F(1, 325) = 11.60, p = .001, η^2_p = .03, annoyed, F(1, 325) = 15.53, p = < .001, η^2_p = .05, and frustrated F(1, 325) = 6.78, p = .01, η^2_p = .02. These findings suggest that having ever seen a therapist is associated with more inclination to wanting to leave, hide their head in their hands, and become annoyed and frustrated for having had the experience compared to a person who has no prior experience of being with a therapist. Similarly, a main effect was found for the 85 participants who had ever seen a therapist on the state shame measure, F(1, 325) = 21.93, p = < .001, η^2_p = .06. Those who indicated having prior experience with a therapist scored higher on measures of state shame following the induction than those who had never seen a therapist (See Appendix G).

Regarding the differences across the three types of dissociation (e.g., flashback, amnesia, depersonalisation) and sadness (e.g., heavy, sob, gloomy), analysis showed there were significant difference.[1] However, as the construct of dissociation encompasses all three components (Platt & Freyd, 2015; McKeogh et al., 2018), the three types of dissociative experiences were collapsed to form a single experience. This was also done for the three different experiences of sadness.

Trait dissociation and trait shame. Table 1 shows means and standard deviations for the DCI, ESS and their subscales, as well as their correlations.

[1] Regarding the differences across the three types of dissociation (i.e., flashback, amnesia, depersonalisation), there were no significant differences for the single-item shame measure, V= .02, F(2, 156) = 1.59, p = .21, η^2_p = .02, with the covariate of having ever been in therapy controlled for. In contrast, there was a significant difference for state shame, V= .06, F(2, 156) = 5.30, p = .01, η^2_p = .06. Paired sample t-tests showed that more state shame was produced by flashback (M=11.61; SD=5.46), compared to depersonalisation (M=10.33; SD=5.15), while more state shame was produced by amnesia (M=10.83; SD=5.37) compared to depersonalisation, t(156) = -4.58, p = <.001. For sadness, there were no significant differences across experiences of sadness (i.e., sob, heavy, gloomy) for the single-item shame measure with covariate of having ever seen a therapist controlled for, V= .00, F(2, 160) = .10, p = .90, η^2_p = .00, nor for state shame, V= .01, F(2, 131) = .44, p = .65, η^2_p = .01.

Table 1

Means, standard deviations and correlations for the DCI and ESS (n=328).

	Cronbach's Alpha	**Mean**	**SD**	**Correlations r**		
				DCI Total	DCI Detachment	DCI Compartmentalisation
DCI Total	.95	2.05	1.82			
DCI-Detach*	.89	2.41	1.83			
DCI-Compar*	.94	1.70	1.93			
ESS Total	.96	53.46	17.53	.582**	.612**	.521**
ESS-Chara*	.94	23.84	8.75	.614**	.628**	.566**
ESS-Behav*	.92	20.45	6.73	.457**	.498**	.393**
ESS-Bodily	.91	9.18	3.83	.458**	.489**	.403**

*** p < .001. *Detachment, Compartmentalisation, Characterological, Behavioural.*

To assess if differences existed across participants for trait dissociation (DCI) and trait shame (ESS), a between-subjects ANOVA analysis showed no differences for trait dissociation for Experience, $F(1, 322) = .69$, $p = .41$, $\eta^2_p = < .001$, and Relationship Context, $F(1, 322) = .10$, $p = .90$, $\eta^2_p = .00$. Likewise, no significant differences were found for trait shame for Experience, $F(1, 322) = .17$, $p = .68$, $\eta^2_p = < .001$, and Relationship Context, $F(2, 322) = .01$, $p = .98$, $\eta^2_p = < .001$. Further, both trait dissociation and shame showed no significant interaction effects, $F(1, 322) = .30$, $p = .74$, $\eta^2_p = < .001$ and $F(1, 322) = .92$, $p = .40$, $\eta^2_p = < .001$, respectively. Taken together, participants did not vary in their levels of trait shame and trait dissociation across the different experiences. The descriptive statistics for this analysis are presented in Table 2.

Table 2

Means and standard deviations for relationship context (close friend, doctor, alone) by experience (dissociation, sadness) on the ESS and DCI.

	New therapist M (SD) N	**Old therapist** M (SD) N	**Alone** M (SD) N	**Total** M (SD) N
DCI				
Dissociation	2.11 (1.84) 55	2.12 (1.87) 60	2.18 (1.65) 49	2.14 (1.78) 164
Sadness	2.09 (1.96) 57	2.02 (2.02) 54	1.79 (1.58) 53	1.97 (1.86) 164

ESS				
Dissociation	53.96 (16.32) 55	52.15 (16.00) 60	55.63 (17.72) 49	53.80 (16.59) 164
Sadness	53.54 (19.83) 57	54.39 (16.69) 54	51.38 (18.89) 53	53.12 (18.47) 164

Single-item emotions. To assess differences in the eight single-item emotion ratings across the dissociation and sadness experiences for the three relationship contexts (old therapist, new therapist, alone), a 2 (Experience) x 3 (Relationship Context) between-subjects MANOVA was performed on anger, shame, sad, surprised, anxious, guilty, proud, and relaxed/calm ratings (see Table 3).

Table 3

Means and standard deviations for relationship context (old therapist, new therapist, alone) by experience (dissociation, sadness) on 8 single- item emotion ratings.

	New therapist M (SD) N	**Old therapist** M (SD) N	**Alone** M (SD) N	**Total** M (SD) N
Anger				
Dissociation	1.82 (.83) 55	1.76 (.91) 60	1.63 (.81) 49	1.74 (.86) 164
Sadness	1.63 (.79) 56	1.70 (.84) 54	1.47 (.79) 53	1.60 (.81) 163
Shame				
Dissociation	2.20 (.95) 55	2.36 (1.03) 60	1.85 (.74) 49	2.15 (.94) 164
Sadness	2.16 (.87) 56	2.28 (.95) 54	1.61 (.80) 53	2.02 (.92) 163
Sad				
Dissociation	2.17 (1.00) 55	1.98 (.84) 60	2.15 (.96) 49	2.09 (.93) 164
Sadness	2.62 (1.08) 56	3.07 (.98) 54	2.92 (.98) 53	2.88 (1.03) 163
Surprised				
Dissociation	2.86 (1.00) 55	2.86 (1.08) 60	3.13 (1.01) 49	2.94 (1.04) 164
Sadness	1.89 (.98) 56	2.06 (.92) 64	1.70 (.81) 53	1.89 (.91) 163
Anxious				
Dissociation	2.79 (1.19) 55	2.93 (1.16) 60	3.18 (1.11) 49	2.96 (1.16) 164
Sadness	2.34 (1.10) 56	2.25 (.99) 54	2.00 (1.02) 53	2.21 (1.04) 163
Guilty				
Dissociation	1.84 (.90) 55	1.92 (1.03) 60	1.73 (.93) 49	1.83 (.96) 164
Sadness	1.87 (.98) 56	1.90 (.95) 54	1.70 (.86) 53	1.82 (.93) 163
Proud				
Dissociation	1.76 (.97) 55	1.67 (.90) 60	1.64 (1.05) 49	1.69 (.97) 164
Sadness	1.56 (.93) 56	1.67 (.90) 54	1.31 (.68) 53	1.52 (.85) 163
Relaxed/calm				

Dissociation	2.17 (1.12) 55	1.78 (.86) 60	1.93 (1.12) 49	1.96 (1.04) 164
Sadness	1.98 (1.09) 56	2.36 (.91) 54	1.99 (1.00) 53	2.12 (1.02) 163

Given those 85 participants who indicated having ever seen a therapist were significantly different across several measures compared to those who had never been to therapy, this analysis controlled for this variable as a co-variate. There was a significant multivariate effect for the co-variate of having ever attended therapy across the lifespan (V = .07, F(8, 314) = 2.89, p = .004, η^2_p = .07), suggesting that this variable had an impact on the single-item emotions. There were significant multivariate main effects for Experience, V = .41, F(8, 314) = 27.04, p = < .001, η^2_p = .41, and Relationship Context, V = .15, F(16, 630) = 3.11, p = < .001, η^2_p = .07. Additionally, a significant multivariate interaction between Relationship Context and Experience, V = .10, F(16, 630) = 2.14, p = .01, η^2_p = .05, was found. With reference to the multivariate effect for Experience, univariate analysis showed higher ratings for sad, F(1, 321) = 5.12, p = < .001, η^2_p = .15, in the sadness condition compared to the dissociation condition. In contrast, there were higher ratings for surprised, F(1, 321) = 90.64, p = < .001, η^2_p = .23, and anxious, F(1, 321) = 45.01, p = < .001, η^2_p = .11, in the dissociation condition compared to the sadness condition (see Table 2). For the multivariate main effect for Relationship Context, univariate analysis showed ratings were higher for shame, F(2, 321) = 19.36, p = < .001, η^2_p = .07. Post hoc analysis showed that regardless of their experience (i.e., dissociation, sadness), participants felt more shame when with an old therapist (p = < .001) and a new therapist (p = .001), as opposed to when alone. No differences were found for shame between an old and new therapist (p = .16). This suggests that the presence of another

was largely responsible for the higher ashamed ratings across both the dissociation and sadness conditions.

Regarding the multivariate interaction between Relationship Context and Experience, there was a significant interaction for anxious, $F(2, 32) = 3.33$, $p = .04$, $\eta^2_p = .02$, and relaxed/calm, $F(2, 321) = 4.05$, $p = .02$, $\eta^2_p = .03$. In addition, there was a trend towards significance for feeling surprised, $F(2, 321) = 2.91$, $p = .06$, $\eta^2_p = .02$. ANOVA showed there was a significant difference for anxiety when dissociating compared to sadness occured in the presence of an old therapist, $t(112) = .13$, $p = .001$. Similarly, people felt significantly more anxious when experiencing dissociation alone compared to sadness alone $t(100) = .52$, $p = < .001$. This suggests dissociation was a powerful elicitor of anxious feelings especially in more intimate contexts and when alone. Further, there was a trend towards more anxiety in the dissociation experience compared to sadness experience for those seeing a new therapist, $t(109) = .27$, $p = .08$.

Regarding the interaction for relaxed/calm ratings, when with an old therapist, participants reported feeling more relaxed/calm in the sadness experience compared to the dissociation experience, $t(112) = .93$, $p = .001$. There were no differences across dissociation and sadness experiences for relaxed/calm ratings when with a new therapist, $t(109) = .88$, $p = .373$, or when alone, $t(100) = .31$, $p = .72$.

Shame explanations. To assess whether differences existed between experiences of dissociation and sadness for the 7 potential shame explanations, a 2 (Experience) x 3 (Relationship Context) between-subjects MANOVA was performed on ratings for feeling exposed, flawed, a loss of control, isolated/excluded from what is happening inside, isolated/excluded from what is happening in the environment, feeling badly if others

knew what they were experiencing, and feeling judged/rejected if someone was to see them in this way (see Table 4).

Table 4

Means and standard deviations for relationship context (new therapist, old therapist, alone) by experience (dissociation, sadness) for the 7 shame explanations.

	New therapist M (SD) N	**Old therapist** M (SD) N	**Alone** M (SD) N	**Total** M (SD) N
Exposed				
Dissociation	2.81 (1.06) 47	2.54 (1.07) 50	2.99 (1.09) 34	2.76 (1.08) 131
Sadness	2.83 (1.05) 48	3.04 (.95) 45	2.44 (1.09) 31	2.81 (1.03) 124
Flawed				
Dissociation	2.70 (1.06) 47	2.66 (1.00) 50	3.05 (.94) 64	2.77 (1.01) 131
Sadness	2.73 (1.12) 48	2.59 (.91) 45	2.47 (1.04) 31	2.61 (1.03) 124
Loss of control				
Dissociation	2.84 (1.04) 47	3.05 (1.10) 50	3.37 (1.05) 34	3.05 (1.08) 131
Sadness	2.84 (1.01) 48	2.79 (1.02) 45	2.54 (1.26) 31	2.75 (1.08) 124
Isolated				
Dissociation	2.52 (1.03) 47	2.78 (1.07) 50	2.93 (1.15) 34	2.73 (1.08) 131
Sadness	2.06 (1.07) 48	2.11 (.98) 45	2.25 (1.30) 31	2.13 (1.09) 124
Excluded				
Dissociation	2.55 (1.07) 47	2.79 (1.02) 50	3.05 (1.07) 34	2.77 (1.06) 131
Sadness	2.07 (1.03) 48	2.20 (.96) 45	2.16 (1.12) 31	2.14 (1.02) 124
Think badly of you				
Dissociation	2.67 (1.14) 47	2.46 (1.17) 50	2.83 (1.16) 34	2.63 (1.16) 131
Sadness	2.48 (1.12) 48	2.39 (1.00) 45	2.26 (1.25) 31	2.39 (1.11) 124
Judged				
Dissociation	2.71 (1.29) 47	2.64 (1.20) 50	2.99 (1.07) 34	2.75 (1.17) 131
Sadness	2.69 (1.15) 48	2.42 (1.03) 45	2.28 (1.07) 31	2.49 (1.13) 124

This analysis was conducted on ratings given by those who reported at least some shame in either the sadness or dissociative condition (n = 255). The analysis was run with a co-variate of having ever attended therapy across the lifespan, however, it was not significant, V = .05, $F(7, 241)$ = 1.70, p = .11, η^2_p = .05. There was a significant multivariate main effect for Experience, V = .12, $F(7, 243)$ = 4.74, p = < .001, η^2_p = .12, and a multivariate interaction between Experience and Relationship Context, V = .10,

$F(14, 488) = 1.84$, $p = .03$, $\eta^2_p = .05$. No significant effect was evident for Relationship Context, $V = .05$, $F(14, 484) = .21$, $p = .53$, $\eta^2_p = .03$. For Experience, ANOVA ratings for control, $F(1, 247) = 5.93$, $p = .02$, $\eta^2_p = < .001$, isolated, $F(1, 247) = 18.56$, $p = < .001$, $\eta^2_p = .07$, excluded, $F(1, 247) = 24.70$, $p = < .001$, $\eta^2_p = .09$, and judged, $F(1, 247) = 4.28$, $p = .04$, $\eta^2_p = .02$, were significantly higher in the dissociation condition compared to sadness (see Table 3). That is, for participants who indicated some degree of shame, those in the dissociation condition reported feeling an increased loss of control over themselves, isolated and excluded from what is happening inside and around them, and feeling they may be judged negatively or rejected if someone saw them. There was also a trend towards significance for feeling others would think badly or reject them if they knew what they were experiencing, $F(1, 247) = 3.28$, $p = .07$, $\eta^2_p = .01$.

For the significant multivariate interaction between Relationship Context and Experience, ANOVA showed there were significant interaction for ratings of exposed, $F(2, 247) = 4.79$, $p = .01$, $\eta^2_p = .04$, and control $F(2, 247) = 3.29$, $p = .04$, $\eta^2_p = .03$. Simple effects analysis showed that there was no significant difference across experiences of dissociation and sadness for feeling exposed as a result of shame when with a new therapist, $t(92) = .81$, $p = .79$. In contrast, significantly higher scores were evident for feeling exposed with an old therapist in the sadness condition compared to dissociation, $t(93) = .36$, $p = .02$, suggesting that a sense of exposure is higher in those having shame in the sadness versus dissociation experience when with an old therapist. Further, for having the experience alone, participants felt greater exposure when feeling ashamed upon dissociating compared to when experiencing sadness, $t(63) = .68$, $p = .05$. As such, it appears that unique contextual factors were involved for those participants

who, upon explaining why they experienced some levels of shame as a response to experiences of dissociation or sadness, reported feeling exposed.

For feeling one has lost control as a result of experiencing shame, there was no significant difference across experiences of dissociation and sadness when with a new therapist, $t(92) = .90$, $p = .66$. Similarly, when with an old therapist, there was no significance difference across experience, $t(93) = .30$, $p = .25$. When experienced alone, there was a significant difference for feeling a loss of control as a result of shame, $t(63) = .32$, $p = .01$, with this explanation more likely given to account for shame in the dissociation than sadness experience.

To further understand explanations for shame associated with dissociation, differences across the 7 shame explanations just for those participants exposed to the dissociation vignettes were analysed with a repeated measures MANOVA (see Table 5). No significant differences were found, $V = .04$, $F(6, 124) = .77$, $p = .60$, $\eta^2_p = .04$. In addition, the co-variate of having ever attended therapy across the lifespan was not significant, $V = .04$, $F(6, 124) = .77$, $p = .60$, $\eta^2_p = .04$. While there does not seem to be a single significant explanation for experiencing shame about dissociating, all explanations contributed 'somewhat' to participants' shameful feelings. With no shame explanation being significantly stronger than the other, it poses the question of whether certain circumstances play a part when one explanation becomes more responsible for feeling shame when having dissociated.

Table 5

Means and standard deviations for those in the dissociation experiences for all 7 shame explanations.

	Dissociation

	M (SD) N
Exposed	2.75 (1.08) 131
Flawed	2.77 (1.01) 131
Control	3.05 (1.08) 131
Isolated	2.73 (1.08) 131
Excluded	2.77 (1.06) 131
Badly	2.63 (1.16) 131
Judged	2.75 (1.17) 131

Finally, a median split on the single-item shame variable was conducted to assess whether its intensity led to different shame explanations. Significant differences were found across all 7 shame explanations for those with high shame scores compared to those with low shame scores, $V = .24$, $F(7, 247) = 11.34$, $p < .001$, $\eta^2_p = .23$ (see Appendix G).

State shame. For the state shame scale (see Table 6), a significant effect for the co-variate of having ever attended therapy across the lifespan was found, $F(1, 320) = 20.81$, $p < .001$, $\eta^2_p = .06$, indicating that this variable had an impact on state shame. With this controlled, a significant main effect was found for Experience, $F(1, 320) = 7.15$, $p = .01$, $\eta^2_p = .02$, with those in the dissociation condition showing more state shame than those in the sadness condition. No main effect for Relationship Context, $F(2, 320) = .30$, $p = .74$, $\eta^2_p = .00$, was evident; nor was a significant multivariate interaction between Relationship Context and Experience, $F(2, 320) = 1.86$, $p = .16$, $\eta^2_p = .01$, found.

Table 6

Means and standard deviations for relationship context (new therapist, old therapist, alone) by experience (dissociation, sadness) on the state shame scale.

	Mean	**Standard Deviation**
New therapist		
Dissociation (n=55)	10.62	5.04
Sadness (n=56)	10.32	4.88

Old therapist		
Dissociation (n=60)	10.76	5.29
Sadness (n=54)	8.91	4.56
Alone		
Dissociation (n=49)	10.88	4.74
Sadness (n=53)	8.38	5.53
Total		
Dissociation (n=164)	10.75	5.01
Sadness (n=163)	9.22	4.71

Behavioural responses.

For the 7 behavioural responses, the co-variate of having ever been in therapy was significant, $V = .06$, $F(7, 314) = 2.67$, $p = .01$, $\eta^2_p = .06$, indicating that it had an impact on the behavioural responses after experiencing either sadness or dissociation. A significant multivariate main effect was found for Relationship Context, $V = .30$, $F(14, 630) = 7.90$, $p < .001$, $\eta^2_p = .15$, and Experience, $V = .08$, $F(7, 314) = 3.87$, $p = .001$, $\eta^2_p = .08$. In contrast, there was no multivariate effect for the interaction between Relationship Context and Experience, $V = .07$, $F(14, 630) = 1.51$, $p = .10$, $\eta^2_p = .03$ (See Table 7).

Table 7

Means and standard deviations for relationship context (new therapist, old therapist, alone) by experience (dissociation, sadness) for the 7 behavioural responses.

	New therapist M (SD) N	**Old therapist** M (SD) N	**Alone** M (SD) N	**Total** M (SD) N
Talk				
Dissociation	3.11 (1.04) 55	3.14 (1.09) 60	2.76 (1.14) 49	3.02 (1.10) 164
Sadness	3.01 (1.02) 56	3.36 (1.11) 54	2.57 (.96) 53	2.99 (1.08) 163
Leave				
Dissociation	2.10 (.95) 55	2.13 (.93) 60	2.78 (.99) 49	2.32 (1.00) 164
Sadness	1.84 (.86) 56	2.06 (.93) 54	1.90 (.98) 53	1.93 (.92) 163
Hide				
Dissociation	2.40 (1.07) 55	2.19 (1.07) 60	2.48 (.97) 49	2.35 (1.04) 164
Sadness	2.44 (1.03) 56	2.41 (.97) 54	1.93 (.96) 53	2.27 (1.01) 163
Distract				
Dissociation	2.41 (1.04) 55	2.17 (1.00) 60	3.14 (.97) 49	2.54 (1.08) 164
Sadness	2.29 (.98) 56	2.27 (1.04) 54	2.89 (1.01) 53	2.48 (1.05) 163

Annoyed				
Dissociation	2.41 (1.12) 55	2.51 (1.14) 60	2.68 (.99) 49	2.53 (1.09) 164
Sadness	2.40 (1.16) 56	2.36 (1.12) 54	2.11 (.99) 53	2.29 (1.09) 163
Frustrated				
Dissociation	2.05 (1.04) 55	1.99 (1.03) 60	2.08 (1.07) 49	2.04 (1.04) 164
Sadness	1.81 (.96) 56	1.88 (1.02) 54	1.68 (.85) 53	1.79 (.94) 163
Sit				
Dissociation	2.80 (.95) 55	2.90 (1.02) 60	2.70 (1.12) 49	2.81 (1.03) 164
Sadness	2.82 (1.05) 56	3.12 (.89) 54	3.05 (.93) 53	2.99 (.97) 163

Regarding Relationship Context, ANOVA showed that ratings for talk, $F(2, 320) = 8.21$, $p < .001$, $\eta^2_p = .05$, leave, $F(2, 320) = 5.05$, $p = .01$, $\eta^2_p = .03$, and distract, $F(2, 320) = 19.76$, $p < .001$, $\eta^2_p = .11$, were significant. Post-hoc analyses in the Relationship Context showed that, irrespective of experience (i.e., sadness or dissociation), significantly higher ratings were present for having the desire to talk when with an old therapist ($p < .001$) and a new therapist ($p = .01$), compared to when alone. The old therapist and new therapist context did not differ ($p = .16$). Regarding wanting to leave, there was significantly more desire to quickly leave the room from where the experience occurred in the alone context compared to the new therapist context ($p = .004$). No differences were evident between the alone and old therapist contexts ($p = .09$), nor between the old and new therapist contexts ($p = .19$). This suggests that the presence of a new relationship might lessen the impact of wanting to leave. Similarly, wanting to distract attention away from what had happened was significantly higher in the alone context compared to both the new therapist ($p < .001$), and old therapist contexts ($p < .001$). No differences were evident between the latter two contexts ($p = .51$). Here, it seems that, regardless of whether experiencing dissociation or sadness, the need to distract attention away from the experience is heightened when alone. For Experience, univariate analysis showed ratings for leave, $F(1, 320) = 14.77$, $p < .001$, $\eta^2_p = .04$, and

feeling frustrated at oneself or others, $F(1, 320) = 4.67$, $p = .03$, $\eta^2_p = .01$, were significantly higher in the dissociation experience than sadness. In addition, there was a trend towards significance for wanting to sit when experiencing sadness, $F(1, 320) = 3.49$, $p = .06$, $\eta^2_p = .01$.

Discussion

The main purpose of Study 1 was to replicate findings from previous research and to examine whether similar results were present across different relationship contexts. As such, the current study sought to assess whether experiences of dissociation would elevate feelings of shame when with a new therapist, an old therapist, or when alone. An additional aim of this study was to further explore behavioural responses that dissociation gives rise to and seek preliminary shame explanations for participants that reported feeling varying degrees of shame upon exposure to dissociation vignette experiences.

Overall findings

The primary hypothesis that shame would heighten following experiences of dissociation was partly supported. The single-item shame measure did not yield any significant findings; rather, anxiety was evident as an emotion of importance from the single-item measures when with an old therapist and when alone for the dissociation condition compared to the sadness condition. However, higher ratings on the state shame scale across all relationship contexts indicate that temporary experiences of shame increased when one is dissociating compared to when one is experiencing feelings of sadness. Given that both the current study and that by Schultz (2018) utilised the same single-item shame and state shame measures, perhaps the latter is more sensitive. That is, the state shame measure is a five-item indirect measure of shame, where the word

'shame' is not mentioned but manifestations of it are assessed (e.g., feeling humiliated, disgraced). Regarding the assessment of state shame more specifically, Turner (2014) proposes that an "opaque" instrument may lower the likelihood of individuals recognizing the intent of the measure. Therefore, the "opaque" state shame measure used in the current study and by Schultz (2018), may have produced significant shame findings on the basis that participants were not being asked directly about felt shame (Turner, 2014). However, as McKeogh et al. (2018) used the same measures as well and found contextual findings for dissociation on both the single-item and state shame measures, this explanations remains somewhat inconclusive. Nonetheless, the current study's first objective was supported when measured by the state shame measure, but not when assessed with the single-item shame measure. As this differs from the findings of McKeogh et al. (2018), further investigation on whether dissociation activates shame is warranted.

Regarding the unique findings of anxiety, it appears that contextual factors are involved. Perhaps dissociating in a more intimate setting such as when with an old therapist, or when having the experience alone, activates anxiety. Such findings are somewhat consistent with the results from McKeogh et al. (2018), which upon controlling for anxiety, found that feeling anxious was mostly responsible for higher ratings of shame in the dissociation condition. Thus, on the basis of the current findings and those by McKeogh et al. (2018), anxiety appears to be a more ubiquitous response to experiences of dissociation than shame.

According to Gilbert and Andrews (1998), "anxiety appears central to the shame experience, and it is difficult to consider shame without it" (p. 6). Indeed, within

laboratory induced emotions, it has been suggested that examining emotions in isolation remains limited as affective states tend to occur in conjunction with each other, or because one emotion may inadvertently elicit another similar emotional response (Polivy, 1981). Thus, with anxiety being associated with both shame and dissociation (Dorahy et al., 2017a; McKeogh et al., 2018), heightened anxiety in response to experiences of dissociation is not unexpected. Simeon, Riggio-Rose, Guralnik, Knutelska and Nelson (2003) supports the current findings of an apparent dissociation – anxiety association, whereby individuals with depersonalisation disorder reported greater anxiety than healthy controls when responding to measures of anxiety, anger, dissociation and personality. Despite an apparent anxiety-dissociation link, these explanations fail to provide a rationale for why responses of anxiety were found when alone given shame is primarily considered to be a painful and debilitating emotion (Dorahy et al., 2017b).

Another explanation for the unique contextual findings of anxiety in the current study may stem from the idea that anxiety, especially social anxiety, and shame are both self-conscious emotions that share many similarities (Gilbert, 2000). Here, it has been argued that the cognitive and behavioural responses of both shame and social anxiety (i.e., fear of negative evaluation or exposure, avoidance of social contexts) may function as protective strategies in situations when one feels vulnerable, rejected or judged in front of another (Gilbert, 2000). Therefore, participants experiencing dissociation when in the presence of an old therapist may have felt anxious as a means to protect themselves from feeling inferior and worthless in the eyes of the other (shame). However, the findings are not entirely supported by the idea that shame and social anxiety share a considerable

overlap as elevations of anxiety were found as a response to experiences of dissociation also when this experience happened alone.

Moreover, according to McEvoy, O'Connor, and McCarthy (2015), anxiety is a "central issue in all psychological life" (p. 542). Psychodynamically, anxiety is proposed to be a reaction to external or internal (i.e., emotions) danger or threat faced by an individual (Nathanson, 1992; Moore & Fine, 1990). From this lens, anxiety is considered to be an unconscious and automatic response to danger (Shill, 2004; Moore & Fine, 1990). Regarding the current findings, elevations of anxiety in response to dissociative experiences may suggest that dissociation activated unconscious feelings of danger or threat which may induce feelings of shame and resultant anxiety. Anxiety symptoms as signals of internal threat would be more readily available to awareness than feelings like shame operating to activate anxiety. It is also plausible that dissociation is experienced as a threatening internal event, which may activate anxiety or further heighten it.

A final explanation of the unique findings of anxiety in response to dissociative experiences when alone and when with an old therapist can be understood from a cognitive perspective. Here, anxiety arises from a complex interplay of physiological, behavioural and cognitive changes, whereby manifestations of the latter include impaired concentration, difficulty controlling thoughts, and cognitive errors (Beck & Clark, 1997). Further, the recognition of an adverse stimulus leads to the activation of cognitive distortions such as negative automatic thoughts, which are often involuntary and rapid (Beck & Clark, 1997). Regarding dissociation, perhaps there is the possibility that participants who had the dissociative experience subsequently experienced negative cognitions, which led to them beginning to feel anxious. It may be that, when dissociation

occurs, it automatically activates dysfunctional cognitions such as "I am losing control", "I am in danger" or "I am being judged." These cognitions may be buffered in the presence of a new therapist when dissociation occurs, perhaps by account of participants having more broad-based fears about seeing a new therapist. Taken together, dissociation may result in responses of anxiety through the activation of negative cognitions, or it may interfere with an individual's ability to regulate and process their affect, leading to feelings of anxiety. With several recent studies finding that anxiety plays a role in the relationship between dissociation and shame across different relationship contexts (Dorahy et al., 2017a; McKeogh et al., 2018), and given the strong association that shame and anxiety have, future work should examine the unique nature of the dissociation-anxiety link.

Partial support was also found for the second objective, which hypothesised that experiences of dissociation would increase feelings of shame when in the presence of a close other (i.e., new, old therapist) compared to when alone. Regardless of whether one was experiencing sadness or dissociation, ratings on the single-item shame measure were elevated when with an old therapist and a new therapist as opposed to when alone. Elevated shame feelings across experiences when with a close friend or acquaintance, as found by McKeogh et al. (2018), support these findings. That is, being with a significant other (e.g., close friend, acquaintance, new/old therapist) is central to feeling ashamed about dissociative experiences.

Because shame is in essence a relational affect (Dorahy et al., 2013; DeYoung, 2015), it is not surprising that, regardless of whether experiencing sadness or dissociation, people felt more ashamed when in the presence of another as opposed to

when alone. The presence of shame in social contexts can profoundly affect interpersonal relationships (Dorahy, 2010; Dorahy et al., 2015a), where it may serve as a defensive strategy arising from apparent interpersonal social threat (Gilbert & Andrews, 1998). Shame activation from social threat can be considered to be an involuntary response that is submissive in nature, whereby its primary function is to mitigate interpersonal conflict or further perceived judgement (Gilbert & Andrews, 1998). Thus, elevations on the single-item shame measure when in the presence of either a new or old therapist, irrespective of experience, speaks to the relational effect of shame.

Shame explanations. Regarding the shame explanations, it was predicted that all 7 items would be elevated for experiences of dissociation compared to sadness. Unique responses for dissociation were found. Participants who felt varying levels of shame upon dissociating indicated this was due to them feeling isolated and excluded from what was happening inside and around them, and as though they had lost control over themselves. Moreover, participant's responses indicated they also felt they may be judged negatively or rejected for having dissociated which may underpin their feeling of shame in social circumstances. Participants did not appear to feel exposed or that others would think badly of them at feeling ashamed upon dissociating. However, feeling exposed and feeling a loss of control over oneself were the only shame explanations for dissociation that offered significant findings when in the alone context. That is, when dissociation was experienced alone and subsequently gave rise to shame, it (i.e., shame), was primarily accountable for by feeling exposed and having felt a loss of control over ones' actions.

Regarding feeling exposed, these findings can be considered consistent with the concept that shame can be experienced as both the act of exposing or that something in

particular is being exposed (Moore & Fine, 1990). Further, feelings of shame can be defined as experiences where an individual is faced with the fear of exposure (Gilbert & Andrews, 1998). Given the relational properties of shame, feeling exposed during the induction might not be surprising, yet, the only significant dissociative context that led to participants feeling exposed upon experiencing shame was when alone. With exposure being a central pathway to feelings of shame, the experience of dissociation when alone may have been a more powerful activator of shame than the social environment (i.e., when with a new or old therapist). Indeed, Nathanson (1992) states that the experience of shame often follows a moment of exposure that we would preferably like to keep hidden. Further, Schultz (2018) proposes that dissociation may be viewed by some as a flaw that has been exposed. Perhaps then, dissociating when alone was the precursor that activated feeling exposed and subsequently led to shame. Alternatively, when one dissociates alone and feels ashamed of the experience, they may feel more exposed or confronted with having dissociated alone than when in the presence of another. However, as shame is primarily a relational affect (Dorahy et al., 2013), more specific testing of these findings is required.

Interestingly, regardless of the relationship context, participants who dissociated and subsequently indicated feeling some degree of shame indicated they 'somewhat' felt all of the shame explanations. These responses indicate that dissociation in general gives rise to shame explanations that are relevant (e.g., feeling flawed, that others would think badly of you). Such findings are supported by Schultz (2018), who found that the majority of participants who reported feeling ashamed upon having dissociated did so because they felt flawed and exposed. Clinically, the results suggest different

explanations for shame may be evident in different clients who experience dissociation, and a careful explanation of the specific ones relevant for each client may heighten therapeutic precision. In addition, participants' shame explanations were influenced by the intensity in which they experienced the single-item shame measure, suggesting that as shame becomes elevated it too brings forth different explanations. Future empirical work should further seek to clarify what elements of dissociation evoke shame and how the presence of more intimate relationships may affect these constructs (e.g., feeling exposed, judged/flawed, fearing rejection/exclusion).

Behavioural responses. In regards to the seven behavioural responses, there were unique findings for dissociation. Regardless of the relationship context, participants who experienced dissociation reported having the desire to leave the room where it occurred and wanting to direct their frustration towards themselves or someone else. The desire of wanting to leave the room and wishing to direct the frustration towards themselves or another (for having the experience) is related to the different ways a person may escape the experience of shame. According to Nathanson (1992), when faced with the threat of shame, shame is associated with withdrawal behaviours (e.g., wanting to leave), attack of the self (e.g., becoming frustrated at oneself), and attack on others (e.g., turning frustration towards someone else). Thus, it seems that experiencing dissociation in general may give rise to similar behavioural responses as shame.

Further, whether experiencing sadness or dissociation, participants indicated they would prefer to talk to their new or old therapist about the experience compared to when this happened alone. Indeed, McKeogh et al. (2018), also found participants preferred to talk about the experience when it occurred in the presence of a close friend. However, the

same was not true for when with an acquaintance. Put differently, McKeogh et al. (2018) found participants wanted to talk about the experience (e.g., dissociation or sadness) when it occurred in the presence of a close friend rather when it happened alone or with an acquaintance. In contrast, the current study's findings indicate that the presence of either a new therapist, (which was considered akin to the acquaintance context), and an old therapist evokes the desire to talk about the experience compared to when this happens alone. Perhaps then, staying with a new therapist and talking about the experience is more related to intimacy given this did not happen when with an acquaintance (McKeogh et al., 2018). Future work should seek to clarify the interpersonal context that gives rise to talking about the dissociative experience (and sadness).

Final findings of having the desire to leave the room where the experience had occurred indicated that participants across both dissociation and sadness groups favoured wanting to quickly leave when this happened while they were alone. With the addition of wanting to leave when with an acquaintance, this finding is consistent with McKeogh et al. (2018). Likewise, when experiences of either sadness or dissociation in the current study occurred alone, participants wished to distract the attention away and think about something else. In short, regardless of whether one is experiencing dissociation or sadness, being alone appears to elicit escape-like behaviours. It may be that persons' experiencing dissociation (or sadness) when alone are uncertain as how to react. In light of this, future studies should further investigate which behavioural responses are pertinent to the shame of dissociating.

Methodological Considerations

Given the indirect measure of shame (i.e., the state shame scale) was the only significant shame finding in Study 1 (similar to Schulz 2018), it would be useful to examine whether an indirect measure of anxiety would also produce the same results. Put differently, as the single-item rating of anxiety was found to be a significant reaction to experiences of dissociation across two of the relationship contexts in Study 1, it raises the questions as to whether an indirect measure would also garner significant findings. Perhaps the most pressing limitation of the current study though, and what forms the basis of Study 2, surrounds the levels of intimacy produced by the new and old therapist contexts. Given only 20 (6.1%) of the participants in Study 1 reported currently seeing a therapist, (while 25.9% answered having seen a therapist at some point for a mental illness), it was unclear as to how much intimacy the two therapy contexts in fact brought about given the apparent lack of familiarity participants had with the chosen context. As the current study did not control for intimacy (i.e., asking participants how comfortable they felt sharing personal information with a new/old therapist), it is unsure whether being in the presence of a therapist was even conducive to experiencing intimacy. In short, with only such a small number of respondents having actually experienced being with a therapist, and no conclusive results regarding feelings of shame when with a therapist in response to dissociation, it questions the amount of intimacy this variable in fact created. This is especially pertinent as both shame and dissociation are relational constructs that have been proposed to have a negative impact on interpersonal functioning (Dorahy, 2010; Dorahy et al., 2015a). Thus, future work should assess the level of intimacy evoked by each condition. Overall limitations will be discussed further.

Conclusions

This study further examined whether dissociation leads to shame feelings in different relationship contexts. The current study found support for its central hypothesis that dissociation increases shame, but only when assessed with the state shame measure rather than the single-item shame measure. Dissociation producing acute levels of state shame is a somewhat stable finding given both the current study and that by Schultz (2018) found an increase in state shame following dissociative experiences regardless of the relational context in which it was experienced in. As found by McKeogh et al. (2018), feelings of anxiety were also elevated in the dissociation condition regardless of relationship context. Additionally, while responses of shame were not unique to responses of dissociation (i.e., they were also present for sadness), the presence of a close other (e.g., new/old therapist) was significantly related to increases in felt shame. This again speaks to the relational properties of shame. Taken together, acknowledging the limitations, this study contributes to the idea that experiences of dissociation commonly give rise to negative affective states such shame and anxiety across different interpersonal contexts. As such, shame and anxiety, and their relationship with dissociation, warrant more clinical attention given the impact they have on both intrapersonal and interpersonal functioning.

Study 2

The primary findings from Study 1 found that temporary feelings of shame were elevated when dissociation was experienced, thus further supporting the findings of Schultz (2018). However, less clear was the relational context in which the shame of dissociation was felt. McKeogh et al. (2018) found the single-item shame and state shame measures to be heightened following dissociation when in the presence of a close friend,

yet, Study 1 found no support for a contextual relationship between dissociation and shame. Rather, the single-item anxiety measure appeared to be a more ubiquitous response to dissociation. As such, an additional study is warranted to assess whether a relational effect indeed exists between experiences of dissociation and subsequent feelings of shame.

Building directly on the recommendations from Study 1, a possible explanation for the absence of shame following dissociative experiences when with a new and old therapist (and alone) was because participants were not familiar with the context. With around 75% of the respondents never having seen a therapist, it may be that not enough participants were able to accurately respond to measures of shame upon dissociating on the basis of never having experienced the therapy context interaction. Interestingly though, regardless of which experience the participants were given (i.e., dissociation, sadness), heightened shame was evident when with an old and new therapist. Thus, it appears that shame was associated with more intimate contexts (e.g., new/old therapists), but not when dissociation was the activator. However, as Study 1 did not control for intimacy, no clear conclusion can be drawn on why being with a therapist (old or new) did not elevate shame upon dissociation. Nonetheless, the absence of elevated shame in response to experiences of dissociation when with a new/old therapist is an important limitation to consider. Experiencing dissociation and subsequent feelings of shame when with a close other (e.g., close friend), as found by McKeogh et al. (2018), highlights the salience of an intimate interpersonal context in regards to both shame and dissociation. In light of this, and keeping in mind the clinical implications of Study 1 (i.e., working with patients who experience dissociation in a health setting), it was felt that Study 2 needed to

address the issue of intimacy by utilizing a health professional relational context that everyone could relate to. Therefore, the relationship context of when with a 'doctor' was decided upon. Being with a doctor was deemed to be a relational context that most participants would be able to respond to on the proviso of having actually experienced the interaction. In addition, it was felt that the current study needed to include the previously used close friend context on the basis of the unique contextual findings by McKeogh et al. (2018), where a link was found between dissociation and shame in this relationship context. Further, it was felt that being with a doctor and close friend were interpersonal contexts that have a degree of intimacy. As such, the current study will further assess shame as a response to dissociation in the context of three relationships: when with a doctor, when with a close friend, and when alone.

To further address the issue of intimacy, a single control question was included in Study 2 that assessed how comfortable people felt sharing personal information with either their close friend or doctor. Additionally, two personality control questions were included to investigate whether more shame is felt when a person fears rejection in a relationships (which is consistent with an anaclitic personality style) or is more prone to engage in self-criticism (which is consistent with an introjective personality style). These two personality characteristics have been associated with shame (Dorahy & Hanna, 2012; Wu, Dorahy, Johnston, & Hanna, under review). Given no relational differences were found in Study 1 for acute feelings of shame following dissociation, it raises the question of whether a person's personality makes any difference to feelings of shame increasing? Put differently, as temporary feelings of shame were significantly increased regardless of which relationship context dissociation was experienced in, possibly there are other

factors beyond the context in which dissociation occurs in which may influence feelings of shame.

The present study had two hypotheses. First, it was predicted that dissociative experiences would produce increased feelings of shame. Second, it was hypothesised that experiences of dissociation would produce elevated feelings of shame when with a close friend and when with a doctor. In addition, the current study sought to further investigate the shame explanations and behavioural responses that dissociation gives rise to.

Method

Participants

In light of the number of excluded participants in both McKeogh et al. (2018) and Study 1 (approximately 20%), a different platform (Mechanical Turk) was used in the current study. Given the positive reputation Mechanical Turk (MTurk) has for conducting research (Buhrmester, Kwang & Gosling, 2011), it was expected that fewer responses would be excluded from the current study's sample. However, due to increased validity checks (see below), a higher number of respondents were excluded, thus leaving a smaller final sample size than expected.

Of the three hundred and forty one participants that started the survey, 29 did not complete it. In addition, 67 respondents were excluded due to failing one of the 5 validity checks, such as completing the survey in less than five minutes, robot questions (verbal and pictorial), and an absurd question. The mean age of the excluded sample was 37.49 years (SD = 10.57). Slightly more than half of the excluded sample was male (n = 36; 53.7%), compared to female, (n = 31; 46.3%). Chi Square tests showed there was no significant difference in the distribution of gender between the included and excluded sample, χ^2 (2, N = 312), = .08, p = .07. Likewise, ANOVA showed the distribution of age

across samples to be not significant, $F(1, 310) = .67$, $p = .45$, $\eta^2_p = .00$. A total of 245 participants were included in the final sample. Of this final number, ages ranged from 18 – 60 years ($M = 39.34$; $SD = 10.81$), with 127 identifying as male (51.8%) and 118 as female (48.2%). Regarding ethnicity, 189 participants identified as White/Caucasian American (77.1%), 18 (7.3%) identified as either Asian American or African American, 12 identified as Hispanic American (4.9%), while the remainder identified as Multiracial ($n = 6$; 2.4%) and Native American ($n = 2$; .8%). The majority of the participants were American citizens ($n = 239$; 97.6%), while 3 identified as a mix of other groups (e.g., Turkey, Bahamas, Canada). Three participants did not answer this question. Almost half of the participants were married ($n = 109$; 44.5%), 78 were single (31.8%), 53 were in a relationship (21.6%), 3 were separated (1.2%), while 2 were widowed (.8%). Almost half ($n = 112$; 45.7%) of the participants had completed a Bachelor's degree, 63 (25.7%) a course or diploma, 22 (9%) a Master's degree, four a Ph.D. (2.3%), three 'other' (1.2%), and one reported leaving High School before finishing (.4%). Finally, regarding having been diagnosed with any mental health difficulties, 51 (20.8%) participants stated 'yes' while 194 (79.2%) stated 'no.' Of those who stated 'yes', 34 participants (13.9%) identified having an anxiety disorder, 30 (12.2%) a mood disorder, 9 (3.7%) either attention deficit hyperactivity disorder or post-traumatic stress disorder, 2 (.8%) dissociative identity disorder or substance abuse disorder, and 1 (.4%) a personality disorder, an eating disorder, autism or 'other.'

Measures

Demographics. The same demographic and mental health questions from Study 1 were used in the present study. Two additional experimental control questions were

included which read, ‘do you currently have a close friend?’ and ‘do you have a doctor whom you see at least occasionally?’

Trait Dissociation and trait shame. The DCI and ESS were again used to assess detachment and compartmentalisation, and trait shame respectively in participants. In the current study, the Cronbach’s alpha coefficient for the DCI Total was .93 and the ESS Total scale .97.

Intimacy and personality control questions. To address intimacy levels, participants in the doctor and close friend contexts across both experiences were asked a question which read, “how comfortable do you feel sharing personal information with your doctor/close friend?” Participants rated their levels of intimacy upon completion of their survey on a five-point scale from 0 (not at all) to 4 (extremely). In regards to the personality questions, two questions drawn from the Depressive Experiences Questionnaire (DEQ) were chosen as these most typically capture the two personality structures as formulated by Blatt (1974) – anaclitic and introjective personality orientation (Riley & McCranie, 1990). The DEQ, developed by Blatt et al. (1976), is a 66-item Likert scale that measures attitudes and feelings about interpersonal and self relations (Riley & McCranie, 1990). Question 28 from the DEQ read, “I am very sensitive when around others for signs of rejection,” and represents an anaclitic personality orientation. Question 64 read, “I tend to be very critical about myself,” and was chosen to reflect an introjective personality orientation. Participants responded to these two questions at the end of completing the survey on a 7-point scale ranging from 1 (strongly disagree) to 7 (strongly agree).

Experimental stimuli

Vignettes and measures of shame. The same 18 vignettes used in McKeogh et al. (2018) and Study 1 were used in the current study along with the same method for assessing shame. As outlined above, the only differences within the vignettes pertained to substituting new and old therapist with doctor and close friend respectively. For example, rather than having an appointment with a therapist whom one had been seeing for a long time (Study 1, old therapist context), participants in the close friend context in Study 2 were meeting up with a very close friend whom they had known for a long time (see Appendix E).

Procedure

The procedure of Study 2 mostly mimics Study 1 with the addition of participants in the doctor and close friend contexts having to answer a single intimacy control question, while all participants answered two personality control questions. Moreover, as noted, a different online platform was used to recruit participants in the current study. Rather than using CrowdFlower as done in Study 1, the present study used Amazon's Mechanical Turk (MTurk), an online research platform commonly used in social sciences and psychology (Buhrmester et al., 2011). According to Buhrmester el al. (2011), MTurk is superior to other Internet samples in regards to diversity and can be used to obtain data that is high in quality commonly found when using more traditional methods. Participants received $2 US towards their Amazon account upon completion of the survey.

Another addition in Study 2 was related to increased validity checks. That is, all participants were presented with additional validity checks throughout the survey to ensure the data obtained were reliable. Since its launch in 2005, researchers using MTurk

have had reservations about the data's reliability, with concerns mainly pertaining to automated programmes that mimic human responses – more commonly known as 'bots' (Dreyfuss, 2018). To help address this issue, three questions were created. First, prior to starting the survey, all participants had to identify themselves as not being a robot by ticking a box stating, 'I am not a robot.' Second, the absurd question, 'would you feel like wearing socks on your head?' was included in one of the three vignettes that participants read. Participants who did not answer 'not at all' were excluded from the final sample. Last, the final question on the survey asked all participants to state the second and fourth letter of the capital city of the United States of America (i.e., a, h). To further prevent bots from responding, this question was created by inserting a picture of the question rather than having the question typed out. Similar to Study 1, participants read and completed all of the questionnaires online via Qualtrics survey software. The Human Ethics Committee approved all procedures.

Design and analysis

The design of Study 2 was identical to that of Study 1. Experience (dissociation, sadness) and relationship context (close friend, doctor, alone) were the key independent variables, while state shame, shame explanations, as well as behavioural responses were the central dependent variables. Pillai's trace statistics was again shown for MANOVA results and Gabriel's used for post-hoc analysis. Exploratory data analysis identified two outliers which were adjusted accordingly.

Results

Characteristics. Regarding currently having a close friend or a doctor whom one sees occasionally, Chi Square tests revealed that there were no differences in the

distribution across both Experiences (dissociation, sadness) or Relationship Context (alone, close friend, doctor). That is, no significant differences were found for the number of close friends participants reported currently having for Experience, χ^2 (1, N = 245) = 2.05, p = 1.52, and Relationship Context, χ^2 (2, N = 245) = .75, p = .69. Likewise, no significant differences regarding having a doctor whom one sees at least occasionally were present for Experience, χ^2 (1, N = 245) = 1.12, p = .30, and Relationship Context, χ^2 (2, N = 245) = 2.35, p = .31 (see Appendix G).

For the two personality questions, there was no difference in terms of personality styles across groups (see Table 8). For anaclitic personality orientation, there was no significant main effect Experience, F(1, 239) = .75, p = .72, η^2_p = < .001, Relationship Context, F(2, 239) = .34, p = .34, η^2_p = < .001, or the interaction between Relationship Context and Experience, F(2, 239) = .38, p = .68, η^2_p = < .001. Likewise, introjective personality orientation showed no differences for Experience, F(1, 239) = .06, p = .80, η^2_p = < .001, and Relationship Context, F(2, 239) = .57, p = .72, η^2_p = .01, nor the interaction, F(2, 239) = .06, p = .94, η^2_p = < .001. This indicates participants' personality orientation (i.e., being sensitive when around others for signs of rejection, being highly critical of oneself) did not differ across the six conditions.

However, fear of rejection from others was positively correlated with both single-item shame (r = .35, p <. 001) and state shame (r = .44, p <. 001). Likewise, higher self-criticism was positively correlated with single-item (r = .35, p <. 001) and state shame (r = .43, p <. 001). Thus, personality styles appeared to impact immediate shame responses in the presence of dissociation and sadness, and was therefore used as a co-variate in the analysis.

Table 8

Means and standard deviations for relationship context (close friend, doctor, alone) by experience (dissociation, sadness) for the two personality control questions.

	Close friend M (SD) N	**Doctor** M (SD) N	**Alone** M (SD) N	**Total** M (SD) N
Anaclitic				
Dissociation	4.64 (1.79) 36	4.34 (2.03) 41	4.74 (1.77) 39	4.57 (1.87) 116
Sadness	4.22 (2.03) 41	4.42 (1.65) 43	4.47 (1.85) 45	4.37 (1.84) 129
Introjective				
Dissociation	5.19 (1.65) 36	5.34 (1.84) 41	4.95 (1.82) 39	5.16 (1.78) 116
Sadness	5.10 (1.84) 41	5.21 (1.85) 43	5.00 (1.97) 45	5.10 (1.87) 129

Regarding the four conditions that were asked an intimacy control question, ANOVA showed that no significant differences were evident across Experience, $F(1, 157) = 2.49$, $p = .12$, $\eta^2_p = .02$, and Relationship Context, $F(1, 157) = 2.95$, $p = .09$, $\eta^2_p = .02$. Nor was there a significant interaction between Relationship Context and Experience, $F(1, 157) = .71$, $p = .40$, $\eta^2_p = .01$ (see table 9). This suggests that participants did not differ in their levels of comfort regarding sharing personal information when dissociation or sadness occurred in the presence of a close friend and doctor.

Table 9

Means and standard deviations for the close friend and doctor relationship contexts by experience (dissociation, sadness) for the intimacy control question

	Close friend M (SD) N	**Doctor** M (SD) N	**Total** M (SD) N
Experience			
Dissociation	3.64 (1.07) 36	3.49 (1.05) 41	3.56 (1.06) 77
Sadness	3.51 (1.24) 41	3.07 (.99) 43	3.29 (1.14) 84

Finally, as in Study 1, analysis showed there were significant differences for the three different types of dissociative and sadness experiences.[2] However, as done in Study 1, dissociation and sadness were collapsed to form single experiences.

Trait dissociation and trait shame. Similar to Study 1, there were no differences for trait dissociation across Experience, $F(1, 239) = .45$, $p = .50$, $\eta^2_p = <. 001$, Relationship Context, $F(2, 239) = .10$, $p = .90$, $\eta^2_p = <. 001$, and for the interaction effect, $F(2, 239) = 2.48$, $p = .09$, $\eta^2_p = .02$. The same was true for trait shame for Experience, $F(1, 239) = 1.29$, $p = .68$, $\eta^2_p = <. 001$, Relationship Context, $F(2, 239) = 2.17$, $p = .12$, $\eta^2_p = <. 001$, and Relationship Context by Experience, $F(2, 239) = .14$, $p = .87$, $\eta^2_p = <$ .001. This indicates that across the six conditions participants did not differ in their levels of trait dissociation or trait shame (see Table 10).

Table 10

Means and standard deviations for relationship context (close friend, doctor, alone) by experience (dissociation, sadness) on the ESS and DCI.

	Close friend	Doctor	Alone	Total

[2] Some significant differences across the three types of dissociation were found for the single-item shame measure, $V = .18$, $F(2, 114) = 12.79$, $p = <.001$, $\eta^2_p = .18$. The flashback (M=2.62; SD=1.46), $t(115) = 5.03$, $p = <.001$, and amnesia (M=2.51; SD=1.43), $t(115) = -3.76$, $p = <.001$ types showed significantly more shame that the depersonalisation, (M=2.06; SD=1.28), but did not differ from each other, $t(115) = 1.12$, $p = .25$. For the state shame measure significant differences were found across types of dissociation, $V = .11$, $F(2, 114) = 7.33$, $p = <.001$, $\eta^2_p = .14$. Paired sample t-tests showed that depersonalisation was significantly lower than flashback (M=1.92; SD=1.08), $t(115) = 3.84$, $p = <.001$, while flashback and amnesia trended towards significance with the amnesia experience higher, $t(115) = 1.94$, $p = .06$ and also depersonalisation and amnesia, $t(115) = -1.97$, $p = .05$, with the amnesia higher. For sadness, significant differences existed across the three different types of experience for the single-item shame measure, $V = .38$, $F(2, 127) = 39.48$, $p = <.001$, $\eta^2_p = .38$. The sob type, (M=2.61; SD=1.29), showed significantly more shame than gloomy, (M=1.82; SD=1.09), ($t(128) = 7.50$, $p = <.001$, and heavy, (M=1.67; SD=1.00), $t(128) = 8.37$, $p = <.001$. No differences existed across the gloomy and heavy types, $t(128) = 1.59$, $p = .11$. Regarding state shame, significant differences were found for the three different types of sadness experiences, $V = .28$, $F(2, 127) = 24.78$, $p = <.001$, $\eta^2_p = .28$. Similar to the single-item shame measure, the sob type, (M=2.19; SD=1.14) produced more state shame than gloomy, (M=1.78; SD= .94), $t(128) = 5.91$, $p = <.001$, and heavy, (M=1.70; SD=.95), $t(128) = 6.64$, $p = <.001$. The heavy and gloomy types did not differ on state shame, $t(128) = 1.25$, $p = .22$.

	M (SD) N	M (SD) N	M (SD) N	M (SD) N
DCI				
Dissociation	1.23 (.92) 36	1.29 (.95) 41	1.02 (.98) 39	1.19 (.95) 116
Sadness	1.19 (.94) 41	1.11 (.74) 43	1.50 (1.34) 45	1.27 (1.05) 129
ESS				
Dissociation	48.47 (12.53) 36	51.76 (19.72) 41	46.92 (17.21) 39	49.11 (17.63) 116
Sadness	49.44 (17.76) 41	55.63 (17.63) 43	49.91 (19.05) 45	51.67 (18.26) 129

Single-item emotions. With the covariates of fear of rejection from others, $V = 1.00$, $F(7, 231) = 3.46$, $p = .002$, $\eta^2_p = 1.00$, and self-criticism, $V = .05$, $F(7, 231) = 1.86$, $p = .09$, $\eta^2_p = .05$, controlled, there were significant multivariate main effects for Relationship Context, $V = .38$, $F(14, 468) = 7.40$, $p < .001$, $\eta^2_p = .19$, and Experience, $V = .49$, $F(7, 231) = 32.04$, $p < .001$, $\eta^2_p = .50$ for the single-item emotions (i.e., angry, shame, sad, surprised, anxiety, guilty, proud, relaxed). In addition, a significant multivariate interaction between Relationship Context and Experience, $V = .11$, $F(14, 468) = 1.72$, $p = .03$, $\eta^2_p = .05$, was found (see Table 11).

Table 11

Means and standard deviations for relationship context (doctor, close friend, alone) by experience (dissociation, sadness) on 8 single- item emotion ratings.

	Doctor M (SD) N	**Close friend** M (SD) N	**Alone** M (SD) N	**Total** M (SD) N
Anger				
Dissociation	1.37 (.57) 41	1.39 (.54) 36	1.53 (.58) 39	1.43 (.56) 116
Sadness	1.24 (.44) 43	1.39 (.59) 41	1.41 (.52) 45	1.35 (.52) 129
Shame				
Dissociation	2.89 (1.16) 41	2.81 (1.23) 36	1.50 (.65) 39	2.40 (1.22) 116
Sadness	2.41 (.95) 43	2.03 (.83) 41	1.67 (.78) 45	2.03 (.90) 129
Sad				
Dissociation	2.20 (1.18) 41	2.26 (1.12) 36	2.01 (.89) 39	2.16 (1.09) 116
Sadness	2.94 (1.10) 43	3.02 (1.00) 41	3.13 (.102) 45	3.03 (1.04) 129
Surprised				
Dissociation	3.33 (1.09) 41	3.40 (1.35) 36	3.14 (1.08) 39	3.29 (1.17) 116
Sadness	1.92 (.82) 43	1.79 (.67) 41	1.85 (.78) 45	1.84 (.78) 129
Anxious				

Dissociation	3.33 (1.09) 41	3.40 (1.35) 36	3.14 (1.08) 39	3.28 (1.16) 116
Sadness	1.92 (.82) 43	1.79 (.67) 41	1.83 (.86) 45	1.84 (.78) 129
Guilty				
Dissociation	1.72 (1.09) 41	1.54 (.70) 36	1.25 (.39) 39	1.51 (.91) 116
Sadness	1.86 (1.15) 43	1.74 (.91) 41	1.71 (.90) 45	1.78 (.99) 129
Proud				
Dissociation	1.08 (.35) 41	1.06 (.22) 36	1.14 (.43) 39	1.10 (.35) 116
Sadness	1.03 (.14) 43	1.04 (.23) 41	1.11 (.37) 45	1.07 (.27) 129
Relaxed/calm				
Dissociation	1.31 (.62) 41	1.53 (.99) 36	1.41 (.59) 39	1.41 (.74) 116
Sadness	1.50 (.61) 43	1.65 (.79) 41	1.78 (.77) 45	1.64 (.77)129

Regarding the Relationship Context main effect, univariate analysis showed higher ratings for shame, $F(2, 237) = 30.05$, $p < .001$, $\eta^2_p = .23$, with a trend towards significance for guilty, $F(2, 237) = 2.65$, $p = .07$, $\eta^2_p = .02$. Post-hoc analysis shows that, regardless of whether one experienced sadness or dissociation, respondents felt more shame having these experiences when with a doctor or close friend (*ps* < .001) than when alone. No differences were found for shame between doctor and close friend ($p = .13$). For Experience, ANOVA showed higher ratings for shame, $F(1, 237) = 8.71$, $p = .003$, $\eta^2_p = .04$, surprised, $F(1, 237) = 129.34$, $p < .001$, $\eta^2_p = .35$, and anxiety, $F(1, 237) = 129.34$, $p < .001$, $\eta^2_p = .35$, for those who experienced dissociation compared to sadness. In contrast, feeling sad was elevated for those in the sadness condition, $F(1, 237) = 52.44$, $p < .001$, $\eta^2_p = .18$, compared to dissociation, as was feeling guilty, $F(1, 237) = 7.60$, $p = .01$, $\eta^2_p = .03$, and feeling relaxed, $F(1, 237) = 5.10$, $p = .03$, $\eta^2_p = .02$.

For the multivariate interaction between Relationship Context and Experience, there was a significant interaction for shame, $F(2, 239) = 5.51$, $p = .01$, $\eta^2_p = .04$. Univariate analysis showed that people felt significantly more shame when experiencing dissociation compared to sadness in the presence of a close friend ($p = .002$), and doctor ($p = .02$). In the alone condition, the dissociation and sadness did not produce different levels of

shame (p = .17). This suggests that being in the presence of someone familiar, be it an emotionally more intimate relationship or a professionally more intimate relationship brought forth feelings of shame when one had dissociated compared to when one experienced sadness.

Shame explanations. Both covariates were significant for the shame explanations: $F(7, 180) = 4.39$, $p < .001$, $\eta^2_p = .15$ (fear of rejection), and $F(7, 180) = 2.98$, $p = .01$, $\eta^2_p = .10$ (self-criticism). Once controlled for, there remained a significant multivariate main effect for Experience, $V = .20$, $F(7, 180) = 6.46$, $p < .001$, $\eta^2_p = .20$, and Relationship Context, $V = .24$, $F(14, 362) = 3.47$, $p < .001$, $\eta^2_p = .12$. There was no significant multivariate interaction between Relationship Context and Experience, $V = .10$, $F(14, 362) = 1.40$, $p = .16$, $\eta^2_p = .05$ (see Table 12).

Table 12

Means and standard deviations for relationship context (doctor, close friend, alone) by experience (dissociation, sadness) for the 7 shame explanations.

	Doctor M (SD) N	**Close friend** M (SD) N	**Alone** M (SD) N	**Total** M (SD) N
Exposed				
Dissociation	3.36 (1.09) 38	3.33 (.89) 31	2.91 (1.14) 20	3.24 (1.03) 89
Sadness	3.18 (.86) 40	2.93 (.88) 36	2.50 (.86) 29	2.91 (.90) 105
Flawed				
Dissociation	3.32 (1.23) 38	3.30 (1.14) 31	3.33 (.97) 20	3.31 (1.16) 89
Sadness	2.76 (.129) 40	2.45 (1.00) 36	3.11 (.95) 29	2.75 (1.13) 105
Loss of control				
Dissociation	3.78 (1.06) 38	3.96 (1.11) 31	3.62 (1.14) 20	3.81 (1.09) 89
Sadness	2.95 (1.09) 40	2.70 (1.09) 36	2.91 (1.29) 29	2.85 (1.14) 105
Isolated				
Sadness	2.56 (1.37) 38	2.74 (1.16) 31	2.65 (.90) 20	2.56 (1.19) 89
Dissociation	1.95 (1.20 40	1.61 (.74) 36	2.48 (1.24) 29	1.98 (1.12) 105
Excluded				
Dissociation	2.75 (1.26) 38	2.83 (1.17) 31	3.14 (1.07) 20	2.87 (1.19) 89
Sadness	1.92 (1.22) 40	1.79 (.75) 36	2.49 (1.30) 29	2.03 (1.13) 105
Think badly of you				
Dissociation	2.89 (1.21) 38	2.75 (1.22) 31	19.7 (1.16) 20	2.63 (1.24) 89

Sadness	2.35 (1.31) 40	1.83 (.81) 36	2.35 (1.10) 29	2.17 (1.12) 104
Judged				
Dissociation	3.02 (1.23) 38	2.91 (1.21) 31	2.80 (1.23) 20	2.80 (1.23) 89
Sadness	2.63 (1.18) 40	2.24 (1.00) 36	2.46 (1.01) 29	2.45 (1.07) 105

For the Experience main effect, ANOVA showed higher ratings in the dissociation compared to sadness conditions for exposed, $F(1, 186) = 5.48$, $p = .02$, $\eta^2_p = .03$, flawed, $F(1, 186) = 12.59$, $p < .001$, $\eta^2_p = .06$, control, $F(1, 186) = 36.68$, $p < .001$, $\eta^2_p = .17$, isolated, $F(1, 186) = 15.21$, $p < .001$, $\eta^2_p = .08$, excluded, $F(1, 186) = 26.74$, $p < .001$, $\eta^2_p = .13$, and badly, $F(1, 188) = 4.45$, $p = .04$, $\eta^2_p = .02$. Regarding Relationship Context, univariate analysis showed significant effects for exposed, $F(2, 186) = 6.84$, $p = .001$, $\eta^2_p = .07$, badly, $F(2, 186) = 4.69$, $p = .01$, $\eta^2_p = .05$, and judged, $F(2, 186) = 5.20$, $p =. 01$, $\eta^2_p = .05$. There was also a trend towards significance for excluded, $F(2, 186) = 2.92$, $p = .06$, $\eta^2_p = .03$. Post hoc analysis showed that, regardless of their experience, participants reported higher exposure associated with shame when with a doctor, ($p < .001$), and close friend, ($p = .004$), compared to when alone. No differences were found for exposed between doctor and close friend, ($p = .29$). For feeling that others would think badly if they knew about the experience, no differences were evident when comparing close friend to doctor, ($p = .05$), and alone, ($p = .42$), while significantly higher ratings were found when comparing doctor to alone, ($p = .01$). With the exception of feeling significantly more judged when with a doctor compared to alone, ($p = .003$), no other significant differences were found when comparing doctor to close friend, ($p = .11$), and close friend to alone, ($p = .13$).

As in Study 1, the current study further assessed whether differences existed across the 7 shame explanations for just those participants in the dissociation condition.

ANOVA showed significant differences were evident, $V = .22$, $F(6, 81) = 3.86$, $p = .002$, $\eta^2_p = .22$ (see Table 13). The two personality covariates were not significant, $F(6, 81) = 1.96$, $p = .08$, $\eta^2_p = .13$ (fear of rejection), and $F(6, 81) = .48$, $p = .82$, $\eta^2_p = .03$ (self-criticism). Regarding the t-tests comparing the 7 shame explanations, Bonferroni adjustment was made for p on 21 tests leaving a p value of .002. T-tests showed feeling a loss of control was significantly higher than exposed ($p < .001$), flawed ($p < .001$), isolated ($p < .001$), judged ($p < .001$), excluded ($p < .001$), and badly ($p < .001$). Thus, it appears that the key explanation for the shame of dissociating was feeling as though one had lost control over oneself. Further, feeling flawed was higher than isolated ($p < .001$), excluded ($p < .001$), judged ($p < .001$), and badly ($p < .001$), while feeling exposed was higher than badly ($p < .001$), isolated ($p < .001$), and judged ($p = .001$).

Table 13

Means and standard deviations for those in the dissociation experiences for all 7 shame explanations.

	Dissociation M (SD) N
Exposed	3.25 (1.04) 89
Flawed	3.12 (1.16) 89
Control	3.81 (1.09) 89
Isolated	2.64 (1.19) 89
Excluded	2.87 (1.19) 89
Badly	2.63 (1.24) 89
Judged	2.90 (1.24) 89

Finally, to assess whether the intensity of the single-item shame measure resulted in different explanations of shame, a median split was conducted on this variable. Significant differences were found across all 7 shame explanations for those with high shame scores compared to those with low shame scores, $V = .19$, $F(7, 184) = 6.23$, $p < .001$, $\eta^2_p = .19$ (see Appendix G).

State shame. Regarding state shame, a significant effect for both fear of rejection, $F(1, 237) = 17.85$, $p < .001$, $\eta^2_p = .07$, and self-criticism covariates, $F(1, 237) = 8.76$, $p = .003$, $\eta^2_p = .04$, were found. With these controlled, a significant main effect was found for Relationship Context, $F(2, 237) = 5.22$, $p = .01$, $\eta^2_p = .04$, as well as a significant multivariate interaction between Relationship Context and Experience, $F(2, 237) = 3.28$, $p = .04$, $\eta^2_p = .03$. No main effect for Experience was evident, $F(1, 237) = 1.58$, $p = .21$, $\eta^2_p = .03$ (see Table 14). For Relationship Context, state shame scores were significantly higher when with a doctor compared to when alone ($p = .01$), while a trend towards significance for increased state shame when with a doctor compared to when with a close friend ($p = .05$), was evident. State shame scores did not differ between a close friend and being alone ($p = .28$). For the interaction effect, a trend towards significantly higher state shame scores when dissociating than when sad in the presence of a doctor ($p = .09$) was evident. There were no significant findings for close friend ($p = .11$), or alone ($p = .18$) across experiences.

Table 14

Means and standard deviations for relationship context (doctor, close friend, alone) by experience (dissociation, sadness) on the state shame scale.

	Mean	**Standard Deviation**
Doctor		
Dissociation (n=41)	2.36	1.09
Sadness (n=43)	2.11	1.02
Close friend		
Dissociation (n=36)	2.11	.89
Sadness (n=41)	1.76	.75
Alone		
Dissociation (n=39)	1.69	.70
Sadness (n=45)	1.89	.92

Total		
Dissociation (n=116)	2.06	.95
Sadness (n=129)	1.89	.91

Behavioural responses. For the 7 behavioural responses, both covariates were significant: fear of rejection, $F(2, 231) = 2.96$, $p = .01$, $\eta^2_p = .08$; self-criticism, $F(2, 231) = 3.25$, $p = .003$, $\eta^2_p = .09$. With these controlled, a multivariate main effect was found for Relationship Context, $V = .31$, $F(14, 464) = 6.18$, $p < .001$, $\eta^2_p = .16$, and Experience, $V = .14$, $F(7, 231) = 5.15$, $p < .001$, $\eta^2_p = .14$. In addition, there was a significant multivariate interaction between Relationship Context and Experience, $V = .20$, $F(14, 464) = 3.63$, $p < .001$, $\eta^2_p = 1.00$ (see Table 15).

Table 15

Means and standard deviations for relationship context (doctor, close friend, alone) by experience (dissociation, sadness) for the 7 behavioural responses.

	Doctor M (SD) N	**Close friend** M (SD) N	**Alone** M (SD) N	**Total** M (SD) N
Talk				
Dissociation	3.24 (1.14) 41	3.05 (.96) 36	2.91 (1.11) 39	3.07 (1.08) 116
Sadness	2.60 (.83) 43	3.49 (.97) 41	2.29 (.77) 45	2.78 (.99) 129
Leave				
Dissociation	2.11 (.97) 41	1.98 (1.01) 36	2.72 (1.03) 39	2.28 (1.05) 116
Sadness	1.99 (.94) 43	1.78 (.83) 41	1.76 (.72) 45	1.84 (.83) 129
Hide				
Dissociation	2.22 (1.08) 41	2.08 (1.13) 36	1.81 (.95) 39	2.04 (1.06) 116
Sadness	2.12 (1.07) 43	1.94 (.84) 41	2.07 (1.00) 45	2.04 (.98) 129
Distract				
Dissociation	2.31 (1.13) 41	2.85 (1.12) 36	2.92 (1.20) 39	2.68 (1.20) 116
Sadness	2.63 (1.13) 43	2.72 (1.05) 41	3.02 (.92) 45	2.80 (1.04) 129
Annoyed				
Dissociation	2.77 (1.29) 41	2.85 (1.26) 36	1.93 (.93) 39	2.51 (1.23) 116
Sadness	2.68 (1.03) 43	2.53 (.96) 41	2.41 (1.03) 45	2.60 (1.02) 129
Frustrated				
Dissociation	1.33 (.58) 41	1.27 (.64) 36	1.39 (.59) 39	1.33 (.57) 116
Sadness	1.20 (.53) 43	1.36 (.53) 41	1.45 (.63) 45	1.34 (.58) 129
Sit				
Dissociation	2.82 (1.02) 41	3.10 (.93) 36	2.79 (1.03) 39	2.90 (1.00) 116

Sadness	3.21 (.90) 43	3.43 (.89) 41	3.06 (.92) 45	3.23 (.91) 129

For Relationship Context, ANOVA showed significant ratings for talk, $F(2, 237) = 9.83$, $p < .001$, $\eta^2_p = .08$, distract, $F(2, 237) = 4.64$, $p = .01$, $\eta^2_p = .04$, and annoyed, $F(2, 237) = 10.21$, $p < .001$, $\eta^2_p = .08$. There was a trend towards significance for leave, $F(2, 237) = 2.86$, $p = .06$, $\eta^2_p = .02$, and sit, $F(2, 237) = 2.95$, $p = .05$, $\eta^2_p = .02$. Post-hoc analysis showed that, regardless of the experience, significantly higher ratings were present for having the desire to talk when with a close friend compared to both when alone ($p < .001$), and when with a doctor ($p = .02$). The same was true when comparing the doctor and alone contexts ($p = .03$)**.** That is, participants indicated a stronger desire to talk about the occurrence when with a close friend and doctor compared to when alone, while those in the presence of a close friend favoured talking when compared to being with a doctor.

Regarding distraction, there was significantly more desire to distract attention away from the experience when alone compared to when with their doctor ($p = .003$). No differences were evident between the doctor and close friend context ($p = .07$), nor between the close friend and alone context ($p = .26$). For getting annoyed at oneself for having the experience, significantly higher ratings were found when with a doctor ($p < .001$) and close friend ($p = .002$) compared to when alone. The doctor and close friend context did not differ ($p = .47$). For Experience, univariate analysis showed significant ratings in the dissociation compared to the sadness condition for having the desire to talk, $F(1, 241) = 4.93$, $p = .03$, $\eta^2_p = .02$, and leave, $F(1, 239) = 12.10$, $p < .001$, $\eta^2_p = .05$. Wanting to sit was elevated when experiencing sadness compared to dissociation, $F(1, 241) = 7.29$, $p = .01$, $\eta^2_p = .03$. For the interaction, significant results were evident for

talk, $F(2, 237) = 8.12$, $p < .001$, $\eta^2_p = .06$, and leave, $F(2, 237) = 5.56$, $p = .004$, $\eta^2_p = .05$, while a trend towards significance for annoyed was evident, $F(2, 237) = 3.15$, $p = .05$, $\eta^2_p = .03$. Post-hoc analysis showed that wanting to talk about the experience was significantly higher when dissociating than when sad in the presence of a doctor, *(*$p = .01$), and alone, ($p = .01$). In contrast, when with a close friend, participants reported a greater desire to wanting to talk about the occurrence when experiencing sadness, ($p = .04$). Regarding leave, participants reported significantly higher ratings when dissociating compared to being sad when alone ($p < .001$). No differences for a desire to leave were found across experiences in the close friend ($p = .51$), and doctor contexts ($p = .53$).

Discussion

This present study sought to further clarify whether dissociation activates shame across different interpersonal engagements. This study built directly on the recommendations stemming from Study 1 and on the basis of the findings by McKeogh et al. (2018), by examining the shame of dissociating across more intimate relationship contexts. Thus, shame and dissociation were assessed when with a doctor, close friend and alone. A further exploration of shame explanations, behavioural responses and personality orientation in regards to dissociation and shame was also carried out.

Overall findings

Findings from the current study somewhat support its first hypothesis that experiences of dissociation would lead to elevated feelings of shame. Results indicated that dissociative experiences (compared to sadness) significantly increased felt shame when measured with the single-item shame measure. However, as the emotional responses of anxiety and surprise were also associated with experiences of dissociation, it

appears that shame is not a unique response. As both McKeogh et al. (2018) and Study 1 found anxiety to be of significance following experiences of dissociation, these findings only speak further to the unpleasant emotions dissociation brings forth. The state shame scale did not yield any findings of significance for dissociative experiences in general when compared to sadness. Regarding the latter, further investigation of the activation of acute shame in response to dissociation is warranted given the differences in findings for state shame across studies 1 and 2, and that of McKeogh et al. (2018) and Schultz, (2018).

The second hypothesis that dissociation would lead to elevated feelings of shame when with a close other was more strongly supported. First, the current study found shame to be elevated when experiences of dissociation compared to sadness occurred in the presence of a close friend and doctor rather than alone on the single-item shame measure. This is consistent with the contextual findings of McKeogh et al. (2018), whereby shame was activated when with a close friend. A trend was also identified towards more acute feelings of shame (as measured by the state shame scale) occurring upon dissociation when in the presence of a doctor. Indeed, McKeogh et al. (2018) found state shame was higher in the close friend context when experiencing dissociation rather than sadness. Second, both experiences of sadness and dissociation elevated shame feelings on the single-item instrument when with a doctor and close friend rather than when this was experienced alone. Third, increased temporary feelings of shame were evident when with a doctor across both experiences. Last, a trend was evident towards experiencing acute shame feelings when dissociation rather than sadness occurred in the presence of a doctor on the state shame measure. Taken together, these findings suggest

that intimate relationships, whether in the form of an emotional (close friend) or professional (doctor) close other, gives rise to feelings of shame upon experiencing dissociation compared to sadness. Thus, in light of the findings by McKeogh et al. (2018) and Study 1, shame does not appear to be a ubiquitous emotional response to dissociative experiences. Rather, the shame of dissociating is felt when experienced in the context of a more intimately connected other (e.g., close friend, doctor), further highlighting the role that intimacy appears to play in regards to shame and dissociation.

Shame explanations. As seen in Study 1, regardless of the relationship context in which dissociation happens, the shame of dissociating appears to be based upon several different explanations. Participants experiencing dissociation compared to sadness were more likely to explain their felt shame was a result of feeling exposed or flawed in some way, having a loss of control over oneself, feeling isolated and excluded from what was happening inside and around them, and that others would think badly of them if they knew what they were experiencing. In contrast to Study 1, no unique contextual findings for shame explanations were evident when comparing dissociation and sadness experiences. That is, despite shame being a common reaction to experiences of dissociation when in the presence of a doctor or close friend (as found in the current study), no distinct shame explanations were found across the different relationship contexts in the dissociation condition. However, whether experiencing sadness or dissociation, when in the presence of a doctor, participants suggested they felt ashamed because of feeling that others would think badly of them if they knew what they were experiencing, or that they would feel judged negatively if someone saw them in that way. Further, participants in the close friend and doctor contexts explained their shame to be

because of feeling exposed. In short, these contextual explanations for shame when dissociation (or sadness) is experienced again speak to the relational properties of shame (Dorahy et al., 2013; DeYoung, 2015).

Similar to Study 1, when comparing participants' who were low vs. high on single-item shame scores, increased experiences of shame affected the shame explanations. The more shame that was experienced upon dissociating appeared to have brought forth several different explanations. However, in contrast to Study 1, results from the current study showed that dissociation in general (i.e., regardless of the relationship context) could be explained by certain shame explanations. That is, when participants were asked to explain why they had felt shame upon dissociating, feeling a loss of control over oneself was the primary explanation. Additional shame explanations of interest were feeling flawed in some way and exposed – explanations supported by Schulz (2018). Regarding the loss of control more specifically, Gilbert (1997) states that, within the context of humans being motivated to seek acceptance from others, shame relates to the failed ability to control the positive image we desire to have in the eyes of others. Indeed, McKeogh et al. (2018) suggested that fearing a loss of connection with a close other, or sensing one has lost the ability to be in control of themselves, may be associated with dissociation. For feeling exposed, Gilbert (1997) argues that within the therapy context, shame can impact both the therapist and client, whereby both act to avoid shame and the potential of having their weaknesses exposed. In short, these results suggest the key explanations for shame upon generic dissociative experiences are feeling a loss of control, flawed in some way and feeling exposed.

Behavioural responses. In contrast to the results by McKeogh et al. (2018) and Study 1, unique contextual findings for the seven behavioural responses were found for dissociation in the current study. First, when dissociation was experienced in the presence of a doctor or when alone, participants indicated a strong preference to talk about the occurrence (either with their doctor or someone else). Second, when dissociative experiences happened alone, participants wanted to quickly leave the room from where the occurrence took place. Additional support for these two behavioural responses as outcomes of experiencing dissociation was also found. That is, participants indicated that whether they experienced dissociation with a close friend, doctor or alone, they had more desire to leave the room or talk about the experience compared to when experiencing sadness. Finally, whether experiencing sadness or dissociation, participants had greater desire to talk to their close friend about the occurrence and indicated they would feel annoyed at themselves for having the experience in the presence of their doctor and close friend.

Regarding the contextual findings of wanting to talk in the presence of a doctor more specifically, it appears that this context not only activates shame, but also brings about the preference to talk about the experience. Indeed, McKeogh et al. (2018) found experiencing either dissociation or sadness when in the presence of a close friend evoked shame and brought forth the desire of wanting to have a discussion about the occurrence. In light of this, DeYoung (2015) states that interpersonal engagements can both activate shame feelings but also heal a person's shame when empathy is available, such as in the therapy context. Taken together, the desire of wanting to talk about the experience appears to be a response of interest across all three studies and different relationship

contexts, thus further highlighting the importance of therapists being aware that dissociation may evoke both shame and the desire to talk about it. With this knowledge, therapists may be able to assist their clients in managing shameful feelings by discussing dissociation and shame as they are experienced.

Wanting to quickly leave the room when dissociation was experienced alone is a finding that is partly supported by both McKeogh et al. (2018) and Study 1. Just as shame is associated with wanting to leave, it appears dissociation too elicits withdrawal behaviours. Indeed, participants experiencing either dissociation or sadness when alone in Study 1 and in the current study favoured the escape-like behaviour of wanting to distract attention away from the occurrence.

Intimacy and personality styles. Findings from the current study appear to suggest that intimacy was responsible for higher shame following experiences of dissociation when with a close other (i.e., on the single-item measure). That is, being in an intimate interpersonal engagement, whether in the form of an emotional (close friend) or a professional (doctor) other, were the contexts in which the shame of dissociating was experienced. Further support for this was found from the single intimacy control question that participants in the four close friend and doctor conditions were asked. All participants expressed feeling intimate (i.e., feeling very comfortable sharing personal information) with their doctor or close friend when experiencing dissociation or sadness. These findings suggest that being with a doctor or close friend is a more comforting interpersonal context than being with a new/old therapist, however, as intimacy was not controlled for in Study 1, this explanation remains inconclusive.

For the exploration of whether personality styles impact feelings of shame, the findings indicate that elevated shame is tied to both anaclitic and introjective personality orientation. That is, those participants with increased fear of rejection from others and higher self-criticism had heightened shame scores in response to experiences of dissociation and sadness. In short, these results appear to support the association between shame and personality styles (Dorahy & Hanna, 2012; Wu et al., under review). Yet participants did not differ in their personality orientation across the six conditions. In other words, the unique contextual findings of dissociation activating shame when in the presence of a doctor or close friend was not due to personality factors as questioned in Study 1. Therefore, fearing rejection and being highly critical of oneself is related to increased shame, but does not appear to explain why dissociation was related to shame in the close friend and doctor contexts. This connection seems to be associated with the intimacy of the relationship where dissociation occurs rather than the personality style of the person. Put differently, when the personality variables of rejection and self-criticism are controlled for, there is still a robust connection between dissociation and shame in more intimate relationships, be they emotionally or professionally intimate.

Methodological Considerations

The main limitation of Study 2 is related to the generalizability of the sample. To enhance the quality of responses, the online research platform Mechanical Turk (MTurk) was used rather than Study 1's and McKeogh et al. (2018) platform, Crowdflower. A unique feature of MTurk is its ability to have large participant pools that are more demographically diverse than both other Internet samples and university students (Buhrmester et al., 2011). Moreover, MTurk samples have been found to have better

attention to instructions compared to traditional samples (Buhrmester, Talaifer, & Gosling 2018). Whilst promising, Hauser and Schwarz (2016) argue that MTurk participants are a subject pool that effectively learns how to respond to surveys (as shown by higher attentiveness on manipulation checks), which may suggest they are paying closer attention to tasks (e.g., being aware of the wording of questions). Perhaps then, participants' ability to be more attuned to minor aspects of the vignettes may have impacted the findings of the current study. Future online research into the association between shame and dissociation should be ware of this limitation and attempt to collect data from only one online platform.

Conclusions

Study 2 further investigated whether experiences of dissociation would elevate feelings of shame across more intimate relationship contexts. Support for its central hypothesis was partly found: dissociation heightened shame when assessed by the single-item shame measure. In addition, anxiety was again seen to be an emotion of interest as found by McKeogh et al. (2018) and Study 1. Stronger support was evident for the second objective: dissociative experiences increased feelings of shame when with a close friend and doctor on the single-item shame measure. The results support the findings of McKeogh et al (2018), whereby being with a close friend activated the shame of dissociating. A trend towards feeling more temporary feelings of shame when dissociation was experienced with a doctor also supports the relational importance of shame and dissociation. Further, when both sadness and dissociation was experienced in the presence of a doctor or close friend, it elevated shame feelings on the single-item instrument, while being with a doctor across both experiences increased acute shame

feelings as measured by the state shame scale. In short, these findings appear to highlight the importance of an intimate relational context in regard to linking dissociation and shame. Being in an interpersonal engagement with either a more emotionally (close friend) or professionally (doctor) connected other appears to activate shame feelings upon experiencing dissociation.

General discussion

These two studies investigated whether dissociation would lead to elevated shame, especially when experienced in more intimate interpersonal contexts. Both non-clinical samples offered different findings. In Study 1, dissociation did not produce heightened shame when with a new or old therapist compared to when alone. However, temporary feelings of shame were associated with dissociative experiences regardless of the relationship context in which it occurred, thus supporting the findings of Schultz (2018) who showed elevated state shame to be the result of dissociative experiences. Study 2 found strong support for dissociation when experienced in more intimate contexts (e.g., doctor, close friend) triggering shame, thus supporting the contextual findings of McKeogh et al. (2018). In addition, both studies found anxiety to be an important emotion in regards to dissociation in different relational contexts.

Although both studies show that shame is at least in some contexts reactive to dissociation, several possible explanations exist for the discrepancy in findings. First, as previously argued, given that many of the participants in Study 1 were not familiar with being in therapy (which may have reduced the ability of participants to imagine themselves in that context), perhaps this context did not produce the required levels of intimacy needed for shame to be felt after experiencing dissociation. Indeed, results from

Study 2 and McKeogh et al. (2018) support the importance of an intimate interpersonal engagement when the shame of dissociating is experienced. As intimacy was not controlled for in Study 1, however, differences in results cannot fully be explained by the possible absence of intimacy when in the presence of a new/old therapist. Second, despite the lack of familiarity with the therapy context, it may be that participants did not deem dissociative experiences to be shameful when in the presence of a therapist. Regardless of whether one had ever seen a therapist, it seems plausible that participants would have had a basic understanding that therapy pertains to engaging in intimate discussions about personal problems. Therefore, the absence of significant findings in Study 1 could be because the therapy context (whether old or new) is deemed to be an intimate context where dissociative symptoms are appraised as acceptable. In light of this, perhaps the unique contextual findings of Study 2 are more related to feeling ashamed when in the presence of someone who is not a mental health professional (e.g., doctor, close friend), where dissociative symptoms may be judged as shameful due to them reflecting being out of control, flawed or exposing in the presence of someone who may not understand. That is, experiencing dissociative symptoms when with a doctor and close friend could be seen as more embarrassing, and thus explains why shame was subsequently felt after experiences of dissociation. Interestingly though, all participants in Study 2 said they felt very comfortable sharing personal information with their doctor or close friend (i.e., they felt intimate), despite still responding that they would feel ashamed when experiencing dissociation in those relationships. Sharing personal information and having a dissociative symptom may reflect two different classes of experience, the former being more under the agency of the person (e.g., what is shared and what is not), the latter

seemingly more uncontrollable. Taken together, perhaps sensing the appropriateness of dissociation in given intimate contexts plays a more pivotal role in the activation of shame following dissociation. Future research should investigate the association between dissociation and factors determining intimacy in the face of elevated shame.

Regarding the consistent findings of anxiety across studies 1 and 2, and that of McKeogh et al. (2018), as previously outlined, several explanations exist to support the apparent dissociation-anxiety link. In short, self-conscious emotions such as shame and anxiety do not occur in isolation (Gilbert & Andrews, 1998; Polivy, 1981), and in fact, share many similarities (e.g., fearing exposure or negative evaluation; Gilbert, 2000). Further, anxiety being reactive to dissociation may not be all that surprising given the emotion is argued to play a central role across all psychological experiences (McEvoy et al., 2015). It is considered to be an unconscious reaction (Shill, 2004; Moore & Fine, 1990) to internal or external threat or danger of an individual (Nathanson, 1992). As previously argued, perhaps participants felt anxious as a reaction to the internally threatening/dangerous experience of dissociation. Alternatively, from a cognitive perspective, experiencing distressing dissociative symptoms (e.g., amnesia, flashback) may have evoked distorted cognitions such as "I am being exposed," which subsequently led to anxiety being felt. In light of the significant findings supporting a dissociation-anxiety relationship, future work should investigate the underlying mechanisms of dissociation that activate anxiety.

Both studies, and that of Schultz (2018), began initial explorations of what the shame-inducing elements of dissociation are. In short, feelings of exposure when with an old therapist and a loss of control when alone were the only distinct contextual findings

following experiences of dissociation in the current studies. Nonetheless, all seven shame explanations in both studies were found to partly account for why shame becomes activated following dissociative experiences. Of particular interest though, were the main shame explanations for just those participants in the dissociation condition: sensing a loss control over themselves, feeling exposed, flawed in some way, and isolated and excluded from what was happening inside and around them. Therefore, although no clear consistent explanation has been established to explain the underlying mechanisms of dissociation that elicit shame feelings, there does appear to be several predominant explanations.

Schultz (2018) found feeling flawed and exposed to be the main reasons for clinical participants' felt shame during a dissociation induction task. Here, she argued that the shame experienced might have been related to feeling exposed in the presence of a researcher, or due to feeling flawed for having dissociated. Indeed, Gilbert (1997) states that feeling shame is to feel flawed about something, and attempts to avoid the experience are related to fearing being exposed. Moreover, McKeogh et al. (2018) hypothesised that, along with being unable to control one's internal functioning, dissociation occurring in the presence of a more closely connected other may increase feeling socially excluded and compromise the ability to interact and engage. Perhaps then, participants' explanations of why they felt shame upon dissociating are not all that surprising, thus leading to the tentative conclusion that the shame experienced was related to failed attempts to control the self, feeling flawed and exposed for having dissociated, and fearing exclusion from the interpersonal engagement. Thus, as argued by McKeogh et al. (2018), dissociation occurring in the presence of an intimate other indeed

appears to "act as a natural shamer" (p. 53). In light of this, therapists would benefit from having an understanding of why dissociation is considered to be shameful, and to be aware that individuals are likely to vary in their appraisals of why dissociation causes shame.

Results from the current studies show that no single definitive behavioural response to shame for dissociating exists. Rather, a combination of methods designed to cope with the distressing experience appear consistent. Of note were three shame responses that drew in part on Nathanson's (1992) Compass of Shame: attacking the self (e.g., becoming frustrated and annoyed at oneself), attacking the other (e.g., becoming frustrated with someone else), and wanting to withdraw (e.g., distract attention away and leave the room). In addition, the desire to talk about the experience was found to be a response of interest in both Study 1 and Study 2, and also in McKeogh et al. (2018). Within these findings at least, wishing to talk about the experience (dissociation or sadness) does not appear to be related to Nathanson's (1992) Compass of shame, especially when considering withdrawal and avoidance behaviours. Instead, talking about the occurrence is an approach behaviour and might be better explained by the desire of wanting to heal the felt shame as previously discussed. Interestingly, a growing body of literature on the positive consequences of shame exists to support the current two studies' findings and that of McKeogh et al. (2018). A recent study investigating the interpersonal consequences of shame found that participants preferred to be with another rather than alone upon experiencing shame (de Hooge, Breugelmans, Wagemans & Zeelenberg, 2018). That is, using two non-clinical samples, the authors from this study showed that shame motivated individuals to favour a social approach (e.g., being with another) over

social withdrawal (e.g., being alone). Moreover, when resolving shame in group therapy, DeYoung (2015) argues that responding to shame in a manner that seems most natural (e.g., hiding from the experience) is also considered to be the most toxic. In contrast, she states that a person's least automatic response (e.g., allowing the shame to be exposed) is ultimately the most healing. To best illustrate her point, De Young (2015) uses a metaphor to conceptualize the healing process of shame – "shame needs light and air" (p. 116). Indeed, when investigating the usefulness of therapists' responses to disclosures of shame, Dorahy, Gorgas, Hanna and Wiingaard (2015b) found the most helpful intervention to be discussing with the patient how to best manage their feelings of shame. More specifically, upon watching two video clips of therapy sessions, participants indicated withdrawing from the emotion to be the least helpful whereas interventions aimed at identifying strategies to assist in dealing with shame were rated as the most helpful (Dorahy et al., 2015b). Further, using a clinical sample of 40 participants, 25 of which had a *DSM-IV* dissociative disorder (DD), Dorahy, Gorgas, Seager and Middleton (2017c), examined five different interventions (therapist responses) used when shame is experienced in therapy (feeling-, withdrawal-, management-, cognitive-, and history-focused). Results from this study found individuals preferred the therapist responses that allowed them to remain connected with the shame experience (e.g., cognitive-, feeling-focused interventions; Dorahy et al., 2017c).

Taken together, when dealing with shame in general in therapy, therapists should be aware of the manifestations of shame and the automatic defences intended to reduce the impact on the self it leads to (Nathanson, 1992), and also the client's desire to potentially want to talk about it. Finally, when safely connected with their clients, therapists should

encourage them to feel their painful experiences in ways that promote healing and understanding (DeYoung, 2015),

Practical and Theoretical Implications

There are several aspects of both studies' findings that have potential implications for therapists working in a clinical setting. First, dissociation activating shame in the presence of a close other highlights the salience of intimacy in both shame and dissociation. Whilst not found when experienced in the presence of a new or old therapist, therapists would still benefit from being mindful of dissociation happening during therapy. This is especially important as acute experiences of shame were higher across all of the dissociation conditions in Study 1. Second, as anxiety was also associated with experiences of dissociation in both studies, future work should investigate whether a direct causal link in fact exists between dissociation and feelings of both shame and anxiety. To best test this association, additional work should examine participants in a laboratory to obtain more accurate measures of shame and anxiety. Last, responses of anxiety in both studies further support the importance of acknowledging that negative affective states may become heightened when dissociation occurs. As such, therapists working with clients who experience dissociation should be aware of the relationship between dissociation and painful emotions such as shame and anxiety, and ensure they are informing their clients about this occurrence as it happens.

Methodological Considerations

Both studies had several limitations. First, it remains uncertain as to how generalizable the results are, especially since experiences of dissociation were created in the form of vignettes as opposed to experiential dissociative experiences. Even though

the vignettes were effective in developing experiences of dissociation, such a method is more cognitive than experiential, and therefore, may not mimic dissociative experiences or symptoms. In short, using vignettes to create experiences of dissociation is not the most accurate way to test the two studies' hypotheses. Second, this sample represents a non-clinical group of individuals, which also impacts the generalizability of these results to clinical settings. Replicating these findings with a sample of individuals in therapy for dissociation would add strength to the current body of research that is examining the relationship between shame and dissociation.

Conclusions

The current two studies built upon research by McKeogh et al. (2018) that found dissociation activated shame when in the presence of a close friend. Whilst Study 1 and Study 2 had differing results, a replication of the significant findings of McKeogh et al. (2018) in Study 2 appears to support the importance of an intimate interpersonal context in regards to shame and dissociation. That is, dissociation occurring in the presence of a more emotionally connected other seems to activate shame, at least when that context is not with a therapist. Further, dissociative experiences in general appear to activate temporary feelings of shame, as found by Platt et al. (2017) and Schultz, (2018). In light of these findings, there now exists a small body of evidence supporting the bi-directional relationship between dissociation and shame, where shame seems to trigger dissociation, and dissociation occurring in at least some more intimate interpersonal contexts seems to produce elevated shame feelings (Dorahy et al., 2017a; McKeogh et al., 2018).

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Appendix A: Information sheet

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UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

Information Sheet for Participants

"Dissociation and emotions in the context of relationships: A vignette study"

We are researchers from the University of Canterbury, New Zealand. We are inviting you to participate in a survey study that aims to further understand the association between dissociation (e.g., daydreaming, feeling disconnected from oneself, and not remembering things) and emotions, especially in different relationship contexts. We are seeking participants who are willing to answer some questions in response to reading three short passages. Below is a summary of the research:

Aim of the Study
Dissociation refers to different experiences that range from daydreams to losing track of time, to feeling disconnected from oneself. Studies have shown that dissociation is related to different emotional experiences including embarrassment, sadness, anxiety, shame and anger. This study examines whether dissociative experiences are associated with different emotions when it occurs in three different relationship contexts – when with a close friend, when with a doctor and when alone. Our primary objective is to determine whether dissociative experiences are related to emotions in different relationship contexts.

Procedure
This study is an online questionnaire and can be accessed anywhere there is an internet connection, although a quiet space away from distractions is preferred. Once you have read the information presented here and viewed the consent form below you will be invited to continue to the study. You will be asked basic demographics questions (e.g. gender, age and educational background), and then you will read three short passages and complete some brief surveys about any responses you anticipate you might have to the situation explained in each passage. You will also complete some other short surveys measuring dissociation and emotions you may experience. The study should take no longer than 30 minutes. At the end you will receive a $1.50 credit towards your Amazon account. In the unlikely event completing the study leads to any emotional distress, a set of online resources are provided at the end of the survey.

Treatment of Data
Participation is voluntary and you have the right to withdraw at any stage without penalty. If you withdraw, all information relating to you will be removed. However, once the research has been

completed and all the data merged together it will not be possible to remove your data, as it will be anonymously placed in a data file.

To ensure anonymity your name or identifying information will not be requested.

The data from the study will be destroyed after 10 years in compliance with university requirements.

The results of the project may be published in a scientific journal.

Participation in this study will have no health risk. This project has been reviewed and approved by the University of Canterbury Human Ethics Committee and is safe for human participation. Participants should address any complaints to: The Chair, Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch or email: human-ethics@canterbury.ac.nz.

You may receive a copy of the research results at the conclusion of the project.

Contact Details

You are free to ask any further questions to Kate McKeogh (kmm103@uclive.ac.nz) or Dr. Martin Dorahy (Martin.dorahy@canterbury.ac.nz, 03 364 3416). They will be pleased to discuss any concerns you may have about participation in the project.

If you are interested in continuing, please read the consent form below.

Thank you.

Appendix B: Consent

College of Science

Department of Psychology
Tel: +64 3 364 2382, Fax: + 64 364 2181
Email: kmm103@uclive.ac.nz

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

Date _____

Consent Form

'Dissociation and emotions in the context of relationships: A vignette study'

I have read a full explanation of this project and understand what is involved in participation.

I understand that participation is voluntary and I may withdraw at any time prior to my data being merged with other data.

I understand that any information I provide is anonymous and that any published or reported results can not identify me.

I understand that all data collected for the study will be kept in password protected electronic form, and will be destroyed after 10 years.

I understand the risks associated with taking part and how they will be managed.

I understand that I am able to receive a report on the findings of the study by contacting the researcher at the conclusion of the project.

I understand that for further information I can contact the researcher Kate McKeogh: kmm103@uclive.ac.nz and/or Martin Dorahy: martin.dorahy@canterbury.ac.nz or phone: +64 3 3643 416.

If I have any complaints, I can contact the Chair of the University of Canterbury Human Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

By clicking below, I understand what is required of me and I agree to participate in this research.

Appendix C: DCI

The Detachment and Compartmentalisation Inventory (DCI)

DIRECTIONS
This questionnaire assesses experiences you may have had. For each item, circle the number that best describes how often you have these experiences when NOT under the influence of alcohol or drugs. Circle "0" if it has never happened to you, circle "7" if it happens daily to you. If it occurs sometimes but not daily, circle the number between 1 and 6 that is the best fit for you.

Date_____ Age_____ Sex: M F

1. When listening to someone talk, I suddenly realize I do not hear part or all of what was said.

0	1	2	3	4	5	6	7
Never	Once or twice in my life	No more than once a year	Once every few months	At least once a month	At least once a week	Multiple times Daily a week	

2. What I see looks 'flat' or 'lifeless', as if I am looking at a picture.

0	1	2	3	4	5	6	7
Never	Once or twice in my life	No more than once a year	Once every few months	At least once a month	At least once a week	Multiple times Daily a week	

3. I focus on something going on in my mind and more or less lose track of what is happening around me.

0	1	2	3	4	5	6	7
Never	Once or twice in my life	No more than once a year	Once every few months	At least once a month	At least once a week	Multiple times Daily a week	

4. I feel like I am watching a situation as an observer or spectator.

0	1	2	3	4	5	6	7
Never	Once or twice in my life	No more than once a year	Once every few months	At least once a month	At least once a week	Multiple times Daily a week	

5. I feel divided, as if I have several parts or forces that have feelings, ideas, memories and behaviours that I do not regard as my own.

0	1	2	3	4	5	6	7
Never	Once or twice in my life	No more than once a year	Once every few months	At least once a month	At least once a week	Multiple times Daily a week	

6. I feel as if something or someone has possessed me.

0	1	2	3	4	5	6	7
Never	Once or twice in my life	No more than once a year	Once every few months	At least once a month	At least once a week	Multiple times Daily a week	

7. At times I go into a trance-like state in which I am barely aware, or unaware, of what is happening around me.

0	1	2	3	4	5	6	7
Never	Once or twice in my life	No more than once a year	Once every few months	At least once a month	At least once a week	Multiple times Daily a week	

8. I cross the street where there is no pedestrian crossing or crosswalk (i.e., jaywalk)

0 1 2 3 4 5 6 7

Never Once or twice No more than once Once every few At least once At least once Multiple times
Daily in my life a year months a month a week
a week

9. I have strong feelings that do not seem to belong to me.

0 1 2 3 4 5 6 7

Never Once or twice No more than once Once every few At least once At least once Multiple times
Daily in my life a year months a month a week
a week

10. For no medical or physical reason I cannot feel all or parts of my body.

0 1 2 3 4 5 6 7

Never Once or twice No more than once Once every few At least once At least once Multiple times
Daily in my life a year months a month a week
a week

11. I feel detached from memories of things that have happened to me, as if I had not been involved in them.

0 1 2 3 4 5 6 7

Never Once or twice No more than once Once every few At least once At least once Multiple times
Daily in my life a year months a month a week
a week

12. I "blank out" or "space out" or my mind goes totally empty.

0 1 2 3 4 5 6 7

Never Once or twice No more than once Once every few At least once At least once Multiple times
Daily in my life a year months a month a week
a week

13. People tell me that my behaviour changes drastically, or that I seem like a different person.

0 1 2 3 4 5 6 7

Never Once or twice No more than once Once every few At least once At least once Multiple times
Daily in my life a year months a month a week
a week

14. I find myself in a place and have no idea how I got there or why I am there.

0 1 2 3 4 5 6 7

Never Once or twice No more than once Once every few At least once At least once Multiple times
Daily in my life a year months a month a week
a week

15. I tell a small lie to stop someone being disappointed or cross with me

0 1 2 3 4 5 6 7

Never Once or twice No more than once Once every few At least once At least once Multiple times
Daily in my life a year months a month a week
a week

16. At times I feel disconnected from a body that does not seem like mine.

0 1 2 3 4 5 6 7

Never Once or twice No more than once Once every few At least once At least once Multiple times
Daily in my life a year months a month a week
a week

17. Something inside of me seems to make me do things that I do not want to do.

0 1 2 3 4 5 6 7

Never Once or twice No more than once Once every few At least once At least once Multiple times
Daily in my life a year months a month a week
a week

18. I feel mechanical, like a robot or like I'm not really human.

0	1	2	3	4	5	6	7
Never	Once or twice		No more than once	Once every few	At least once	At least once	Multiple times
	Daily		in my life	a year	months	a month	a week
a week							

19. I look at the clock and realize that time has gone by and I cannot remember what has happened.

0	1	2	3	4	5	6	7
Never	Once or twice		No more than once	Once every few	At least once	At least once	Multiple times
	Daily		in my life	a year	months	a month	a week
a week							

20. I do not feel in control of what my body does as if there is someone or something inside me directing my actions.

0	1	2	3	4	5	6	7
Never	Once or twice		No more than once	Once every few	At least once	At least once	Multiple times
	Daily		in my life	a year	months	a month	a week
a week							

21. I switch back and forth between feelings that seem to belong to me, and feeling that I do not experience as my own.

0	1	2	3	4	5	6	7
Never	Once or twice		No more than once	Once every few	At least once	At least once	Multiple times
	Daily		in my life	a year	months	a month	a week
a week							

22. I feel my sense of time changes and things seem to happen in slow motion or in double time.

0	1	2	3	4	5	6	7
Never	Once or twice		No more than once	Once every few	At least once	At least once	Multiple times
	Daily		in my life	a year	months	a month	a week
a week							

Appendix D: ESS

Experience of Shame Scale (ESS)

Everybody at times can feel embarrassed, self-conscious or ashamed. These questions are about such feelings if they have occurred **at any time in the past year.** There are no 'right' or 'wrong' answers. Please indicate the response which applies to you with a tick.

		Not at all	*a little*	*moderately*	*very much*
1.	Have you felt ashamed of any of your personal habits?	( )	( )	( )	( )
2.	Have you worried about what other people think of any of your personal habits?	( )	( )	( )	( )
3.	Have you tried to cover up or conceal any of your personal habits?	( )	( )	( )	( )
4.	Have you felt ashamed of your manner with others?	( )	( )	( )	( )
5.	Have you worried about what other people think of your manner with others?	( )	( )	( )	( )
6.	Have you avoided people because of your manner?	( )	( )	( )	( )
7.	Have you felt ashamed of the sort of person you are?	( )	( )	( )	( )
8.	Have you worried about what other people think of the sort of person you are?	( )	( )	( )	( )
9.	Have you tried to conceal from others the sort of person you are?	( )	( )	( )	( )
10.	Have you felt ashamed of your ability to do things?	( )	( )	( )	( )
11.	Have you worried about what other people think of your ability to do things?	( )	( )	( )	( )
12.	Have you avoided people because of your Inability to do things?	( )	( )	( )	( )
13.	Do you feel ashamed when you do something wrong?	( )	( )	( )	( )
14.	Have you worried about what other people think of you when you do something wrong?	( )	( )	( )	( )
15.	Have you tried to cover up or conceal things you felt ashamed of having done?	( )	( )	( )	( )
16.	Have you felt ashamed when you said	( )	( )	( )	( )

something stupid?

		Not at all	*a little*	*moderately*	*very much*
17.	Have you worried about what other people think of you when you said something stupid?	( )	( )	( )	( )
18.	Have you avoided contact with anyone who knew you said something stupid?	( )	( )	( )	( )
19.	Have you felt ashamed when you failed in a competitive situation?	( )	( )	( )	( )
20.	Have you worried about what other people think of you when you failed in a competitive situation?	( )	( )	( )	( )
21.	Have you avoided people who have seen you fail?	( )	( )	( )	( )
22.	Have you felt ashamed of your body or any part of it?	( )	( )	( )	( )
23.	Have you worried about what other people think of your appearance?	( )	( )	( )	( )
24.	Have you avoided looking at yourself in the mirror?	( )	( )	( )	( )
25.	Have you wanted to hide or conceal your body or any part of it	( )	( )	( )	( )

Appendix E: Vignettes

Study 1

E1: Old therapist depersonalisation/derealisation context
You have an appointment with your therapist today. You have been seeing this therapist for **a long time** and have a **very good relationship** with them, one where you feel safe, listened to and supported. As the two of you start to talk you become upset about something that happened to you recently. When you begin telling your therapist about what brought this distress on, you start to **feel detached** from your own body as though you are looking down from the ceiling. You begin feeling as if your therapist is a **long way away**, even though they haven't moved. In the presence of your therapist you can hear your own voice, **but the words don't seem to belong to you; they feel distant, foreign and unusual.** How would you feel once this episode ended and you were still with your **therapist?**

E2: Old therapist flashback context
You have an appointment with your therapist today. You have been seeing this therapist for **a long time** and have a **very good relationship** with them, one where you feel safe, listened to and supported. As the two of you start to talk you become upset about something that happened to you recently. When you begin telling your therapist about what brought this distress on, you start **losing contact with your surroundings** and begin to become intensely focused on a very traumatic experience from earlier in your life. You feel like you are **transported back to that time**, seeing what you saw then and feeling all the same painful feelings that occurred during and immediately following the event. You **lose complete connection** with your therapist. After what seems to you like a long time, **you regain a sense** of where you are in the present moment. You notice your therapist and are aware of sweat on your face and brow. How would you feel once this episode ended and you were still with your **therapist?**

E3: Old therapist amnesia context
You have an appointment with your therapist today. You have been seeing this therapist for **a long time** and have a **very good relationship** with them, one where you feel safe, listened to and supported. As the two of you start to talk you become upset about something that happened to you recently. When you begin telling your therapist about what brought this distress on, you begin to feel **disoriented** and start to experience **a sense of drifting off**. Your therapist's words are hard to hear. You then become **blank** and frozen, **unaware of the passage of time**. Suddenly, you appear to **'come to'**, but you are feeling confused and unaware of **what the two of you had been talking about**. You notice yourself in a different and unfamiliar position in the chair and you're **unsure how you came to be sitting this way**. How would you feel once this episode ended and you were still with your **therapist?**

E4: New therapist amnesia context
You are feeling very stressed and attend an appointment with your **new therapist** whom you have had one previous session with. As you begin to discuss your problems, you start

to feel **disoriented** and begin to experience a **sense of drifting off**. Your new therapist's words are hard to hear. You then become **blank** and frozen, **unaware of the passage of time**. Suddenly, you appear to '**come to'**, but you are feeling confused and unaware of **what the two of you had been talking about**. You notice yourself in a different and unfamiliar position in the chair and you're **unsure how you came to be sitting this way**. How would you feel once this episode ended and you were still with your new **therapist?**

E5: New therapist depersonalisation/derealisation context
You are feeling very stressed and attend an appointment with your **new therapist** whom you have had one previous session with. As you begin to discuss your problems, you start to **feel detached from your own body** as though you are looking down from the ceiling. You begin feeling as if **your therapist is a long way away**, even though they haven't moved. In the presence of your new therapist you can hear your own voice, **but the words don't seem to belong to you; they feel distant, foreign and unusual**. How would you feel once this episode ended and you were still with your new **therapist?**

E6: New therapist flashback context
You are feeling very stressed and attend an appointment with your **new therapist** whom you have had one previous session with. As you begin to discuss your problems, you start **losing contact with your surroundings** and your therapist, and begin to become intensely focused on a very traumatic experience from earlier in your life. You feel like you are **transported back to that time**, seeing what you saw then and feeling all the same painful feelings that occurred during and immediately following the event. You **lose complete connection** with your new therapist. After what seems to you like a long time, **you regain a sense of where you are** in the present moment. You notice your new therapist and are aware of sweat on your face and brow. How would you feel once this episode ended and you were still with your new **therapist?**

E7: Alone flashback context
While at home **alone** reading a book, you begin to experience a surge of panic go through your body. You start **losing contact with your surroundings** and begin to become intensely focused on a very traumatic experience from earlier in your life. You feel like you are **transported back to that time**, seeing what you saw then and feeling all the same painful feelings that occurred during and immediately following the event. After what seems to you like a long time, **you regain a sense of where you are** in the present moment. You notice the book on your lap and sweat on your face and brow. How would you feel once this episode ended and you were still **alone?**

E8: Alone amnesia context
While at home **alone** reading a book, you begin to experience a surge of panic go through your body. You begin to feel **disoriented** and start to experience a **sense of drifting off.** Your thoughts are now harder to connect to. You then become **blank** and frozen, **unaware of the passage of time**. Suddenly, you appear to **'come to'**, but you are feeling confused and unaware of **what has happened.** You notice yourself in a different

and unfamiliar position in the chair and you're **unsure how you came to be sitting this way**. How would you feel once this episode ended and you were still **alone?**

E9: Alone depersonalisation/derealisation context
While at home **alone** reading a book, you begin to experience a surge of panic go through you. You start to feel **detached** from your own body as though you are looking down from the ceiling. You begin feeling as though the furniture in the room is **a long way away**. You are aware of your own thoughts, **but somehow they don't seem to belong to you; they appear distant, foreign and unusual**. How would you feel once this episode ended and you were still **alone?**

E10: Old therapist sob context
You have an appointment with your therapist today. You have been seeing this therapist for **a long time** and have a **very good relationship** with them, one where you feel safe, listened to and supported. As the two of you start to talk you become upset about something that happened to you recently. When you begin telling your therapist about what brought this distress on, you notice tears in your eyes and begin to **sob**. In the presence of your therapist tears start to **stream down your face**. How would you feel about being this way while you were still with your **therapist?**

E11: Old therapist heavy context
You have an appointment with your therapist today. You have been seeing this therapist for **a long time** and have a **very good relationship** with them, one where you feel safe, listened to and supported. As the two of you start to talk you remember several people you have drifted away from or lost. You get a **heavy feeling in your body**, and your shoulders and head begin to **drop**. How would you feel about being this way while you were still with your **therapist?**

E12: Old therapist gloomy context
You have an appointment with your therapist today. You have been seeing this therapist for **a long time** and have a **very good relationship** with them, one where you feel safe, listened to and supported. As the two of you start to talk you become upset about something that happened to you recently. While talking with your therapist you start sharing memories of times gone by, memories that you have not recalled for a long while. Some of these memories make you **feel sad** and you notice **becoming quite gloomy** and **feeling a little down**. How would you feel about being this way while you were still with your **therapist?**

E13: New therapist gloomy context
You are feeling very stressed and attend an appointment with your **new therapist** whom you have had one previous session with. As you begin to discuss your problems, you start sharing memories - memories that you have not recalled for a long time. Some of these memories make you **feel sad** and you notice becoming quite **gloomy** and feeling a **little down**. How would you feel about being this way while you were still with your new **therapist?**

E14: New therapist sob context
You are feeling very stressed and attend an appointment with your **new therapis**t whom you have had one previous session with. As you begin to discuss your problems, you start to get upset about something that happened to you recently. In telling your new therapist about what happened, you notice **tears in your eyes** and begin to **sob**. In the presence of your new therapist **tears start to stream down your face**. How would you feel about being this way while you were still with your new **therapist?**

E15: New therapist heavy context
You are feeling very stressed and attend an appointment with your **new therapist** whom you have had one previous session with. As you begin to discuss your problems, you start to notice how many friends you have drifted away from or lost. You get a **heavy feeling in your body,** and your shoulders and head begin to **drop**. How would you feel about being this way while you were still with your new **therapist**?

E16: Alone heavy context
While at home **alone** reading a book, you begin to notice yourself drifting into your thoughts and thinking of friends who you haven't seen in a while. You remember several you have drifted away from or lost. You get a **heavy feeling** in your body, and your **shoulders and head begin to drop**. The book you are reading now seems less interesting. How would you feel about being this way while you were still **alone**?

E17: Alone gloomy context
While at home **alone** reading a book, you start reflecting on times gone by and several memories come back to you. Some of these memories make you feel **sad** and you notice becoming **quite gloomy** and feeling a **little down**. The book you are reading now seems less interesting. How would you feel about being this way while you were still **alone**?

E18: Alone sob context
While at home **alone** reading a book, you begin to feel upset about something that happened to you recently. When you start thinking about it in more depth you notice **tears** in your eyes and begin to **sob.** While alone **tears** start to **stream down your face**. The book you are reading now seems less interesting. How would you feel about being this way while you were still **alone**?

Study 2

E19: Close friend depersonalisation/derealisation context
You are meeting up with a **very close friend** today. You have known this friend for **a long time** and have a **very good relationship** with them, one where you feel safe, listened to and supported. As the two of you start to catch up you become upset about something that happened to you recently. When you begin telling your close friend about what brought this distress on, you start to **feel detached from your own body** as though you are looking down from the ceiling. You begin feeling as if **your close friend is a long way away**, even though they haven't moved. In the presence of your close friend you can hear your own voice, **but the words don't seem to belong to you; they feel**

distant, foreign and unusual. How would you feel once this episode ended and you were still with your close friend?

E20: Close friend flashback context
You are meeting up with a **very close friend** today. You have known this friend for **a long time** and have a **very good relationship** with them, one where you feel safe, listened to and supported. As the two of you start to catch up you become upset about something that happened to you recently. When you begin telling your close friend about what brought this distress on, you start **losing contact with your surroundings** and begin to become intensely focused on a very traumatic experience from earlier in your life. You feel like you are **transported back to that time**, seeing what you saw then and feeling all the same painful feelings that occurred during and immediately following the event. You **lose complete connection** with your close friend. After what seems to you like a long time, **you regain a sense** of where you are in the present moment. You notice your close friend and are aware of sweat on your face and brow. How would you feel once this episode ended and you were still with your close friend?

E21: Close friend amnesia context
You are meeting up with a **very close friend** today. You have known this friend for **a long time** and have a **very good relationship** with them, one where you feel safe, listened to and supported. As the two of you start to catch up you become upset about something that happened to you recently. When you begin telling your close friend about what brought this distress on, you begin to feel **disoriented** and start to experience **a sense of drifting off**. Your close friend's words are hard to hear. You then become **blank** and frozen, **unaware of the passage of time**. Suddenly, you appear to **'come to'**, but you are feeling confused and unaware of **what the two of you had been talking about**. You notice yourself in a different and unfamiliar position in the chair and you're **unsure how you came to be sitting this way**. How would you feel once this episode ended and you were still with your close friend?

E22: Doctor depersonalisation/derealisation context
You have an appointment with your **doctor** today. You have been seeing them for **a long time** and have a **good relationship** with them, one where you feel safe, listened to and supported. As the two of you start to talk you become upset about something that happened to you recently. When you begin telling your **doctor** about what brought this distress on, you start to **feel detached from your own body** as though you are looking down from the ceiling. You begin feeling as if **your doctor is a long way away,** even though they haven't moved. In the presence of your **doctor** you can hear your own voice, **but the words don't seem to belong to you; they feel distant, foreign and unusual.** How would you feel once this episode ended and you were still with your **doctor**?

E23: Doctor flashback context
You have an appointment with your **doctor** today. You have been seeing them for **a long time** and have a **good relationship** with them, one where you feel safe, listened to and supported. As the two of you start to talk you become upset about something that

happened to you recently. When you begin telling your **doctor** about what brought this distress on, you start **losing contact with your surroundings** and begin to become intensely focused on a very traumatic experience from earlier in your life. You feel like you are **transported back to that time**, seeing what you saw then and feeling all the same painful feelings that occurred during and immediately following the event. You **lose complete connection** with your **doctor**. After what seems to you like a long time, **you regain a sense** of where you are in the present moment. You notice your **doctor** and are aware of sweat on your face and brow. How would you feel once this episode ended and you were still with your **doctor?**

E24: Doctor amnesia context
You have an appointment with your **doctor** today. You have been seeing them for **a long time** and have a **good relationship** with them, one where you feel safe, listened to and supported. As the two of you start to talk you become upset about something that happened to you recently. When you begin telling your **doctor** about what brought this distress on, you begin to feel **disoriented** and start to experience **a sense of drifting off**. Your **doctor's** words are hard to hear. You then become **blank** and frozen, **unaware of the passage of time**. Suddenly, you appear to **'come to'**, but you are feeling confused and unaware of **what the two of you had been talking about**. You notice yourself in a different and unfamiliar position in the chair and you're **unsure how you came to be sitting this way**. How would you feel once this episode ended and you were still with your **doctor?**

E25: Close friend sob context
You are meeting up with a **very close friend** today. You have known this friend for **a long time** and have a **very good relationship** with them, one where you feel safe, listened to and supported. As the two of you start to catch up you become upset about something that happened to you recently. When you begin telling your close friend about what brought this distress on, you notice tears in your eyes and begin to sob. In the presence of your close friend tears start to stream down your face. How would you feel about being this way while you were still with your **close friend**?

E26: Close friend heavy context
You are meeting up with a **very close friend** today. You have known this friend for **a long time** and have a **very good relationship** with them, one where you feel safe, listened to and supported. As the two of you start to catch up you remember several people you have drifted away from or lost. You get a heavy feeling in your body, and your shoulders and head begin to drop. How would you feel about being this way while you were still with your close friend?

E27: Close friend gloomy context
You are meeting up with a **very close friend** today. You have known this friend for **a long time** and have a **very good relationship** with them, one where you feel safe, listened to and supported. As the two of you start to catch up you become upset about something that happened to you recently. While talking with your close friend you start sharing memories of times gone by, memories that you have not recalled for a long while.

Some of these memories make you feel sad and you notice becoming quite gloomy and feeling a little down. How would you feel about being this way while you were still with your close friend?

E28: Doctor gloomy context
You have an appointment with your **doctor** today. You have been seeing them for **a long time** and have a **good relationship** with them, one where you feel safe, listened to and supported. As the two of you start to talk you become upset about something that happened to you recently. While talking with your **doctor** you start sharing memories of times gone by, memories that you have not recalled for a long while. Some of these memories make you **feel sad** and you notice **becoming quite gloomy** and **feeling a little down**. How would you feel about being this way while you were still with your **doctor?**

E29: Doctor heavy context
You have an appointment with your **doctor** today. You have been seeing them for **a long time** and have a **good relationship** with them, one where you feel safe, listened to and supported. As the two of you start to talk you remember several people you have drifted away from or lost. You get a **heavy feeling in your body**, and your shoulders and head begin to **drop**. How would you feel about being this way while you were still with your **doctor?**

E30: Doctor sob context
You are meeting up with a **doctor** today. You have been seeing them for **a long time** and have a **good relationship** with them, one where you feel safe, listened to and supported. As the two of you start to catch up you become upset about something that happened to you recently. When you begin telling your **doctor** about what brought this distress on, you notice tears in your eyes and begin to sob. In the presence of your doctor tears start to stream down your face. How would you feel about being this way while you were still with your **doctor**?

Note: The alone dissociation and sadness contexts for Study 2 are identical to those from Study 1.

Appendix F: Outcome measures

F1: Single-item emotions

	Not at all (0)	A little (1)	Somewh at (2)	A lot (3)	Extremely (4)
Angry					
Ashamed					
Sad					
Surprised					
Anxious					
Guilty					
Proud Relaxed/Calm					

F2: Shame explanations

	Not at all (0)	A little (1)	Somewh at (2)	A lot (3)	Extremely (4)
Feeling exposed					
Feeling flawed in some way					
Feeling like you had lost control over yourself					
Feeling somewhat isolated or excluded from what is happening inside you					
Feeling somewhat isolated or excluded from what is happening around you					
Feeling that others would think badly or reject you if they knew what you were experiencing					
Feeling that you would be judged negatively or rejected if someone saw you like that					

F3: State shame scale

	Not feel this way at all	Feel this way a little	Feel this way somewhat	Feel this way moderately	Feel this way very strongly
Feel like you wanted to sink into the floor and disappear.					
Feel small.					
Feel like they were a bad person.					
Feel humiliated, disgraced.					
Feel worthless, powerless.					

F4: Behavioural responses to shame – new/old therapist, doctor/close friend contexts

1. Talk to your new/old therapist or close friend/doctor about the experience
2. Quickly leave the room to get away from your new/old therapist or close friend/doctor
3. Hide your head in your hands or divert your gaze from your new/old therapist or close friend/doctor
4. Distract attention away from what happened and talk to your new/old therapist or close friend/doctor about something else
5. Get annoyed with yourself for having this experience in the presence of your new/old therapist or close friend/doctor
6. Get frustrated at your new/old therapist or close friend/doctor for being with you when you had this experience
7. Sit calmly with your new/old therapist or close friend/doctor

F5: Behavioural responses to shame – alone context

1. Talk to someone about it
2. Quickly leave the room where it occurred
3. Hide your head in your hands
4. Distract attention away from what happened and think about something else
5. Get annoyed with yourself for having this experience
6. Feel frustrated and think of someone who recently annoyed you and turn your frustration towards them
7. Sit calmly on your own

F6: Intimacy control question (close friend and doctor context – Study 2)

	Not at all	A little	Somewhat	A lot	Extremely
How comfortable do you feel sharing personal information with your doctor/close friend?					

F7: Personality control question (all relationship contexts – Study 2)

	Strongly disagree	Disagre	Somewhat disagree	Neither agree or disagree	Somewhat agree	Agree	Strongly agree
I am very sensitive when around others for signs of rejection							
I tend to be very critical of myself							

Appendix G: Tables

G1: Means and standard deviations for those currently in therapy vs. those not on 8 single-item emotion ratings.

	In therapy M (SD) N	**Not in therapy** M (SD) N	**Total** M (SD) N
Emotions			
Anger	2.13 (1.23) 20	1.64 (.80) 308	1.67 (.84) 328
Shame	2.32 (1.11) 20	2.07 (.92) 308	2.09 (.93) 328
Sad	2.78 (1.20) 20	2.47 (1.04) 308	2.49 (1.05) 328
Surprised	2.68 (1.26) 20	2.40 (1.10) 308	2.41 (1.11) 328
Anxious	3.03 (1.12) 20	2.55 (1.16) 308	2.58 (1.17) 328
Guilty	2.12 (1.18) 20	1.81 (.93) 308	1.83 (.94) 328
Proud	1.58 (.90) 20	1.61 (.91) 308	1.60 (.91) 328
Relaxed/calm	2.12 (1.09) 20	2.02 (1.03) 308	2.03 (1.02) 328

G2: Means and standard deviations for those currently in therapy vs. those not on 6 behavioural responses.

	In therapy M (SD) N	**Not in therapy** M (SD) N	**Total** M (SD) N
Behaviours			
Talk	3.55 (.99) 20	2.96 (1.08) 308	3.00 (1.08) 328
Leave	2.28 (1.15) 20	2.11 (.97) 308	2.12 (.98) 328
Hide	2.75 (1.25) 20	2.28 (1.00) 308	2.30 (1.03) 328
Distract	2.60 (1.24) 20	2.50 (1.06) 308	2.51 (1.05) 328

Annoyed	2.77 (1.23) 20	2.39 (1.08) 308	2.41 (1.10) 328
Frustrated	2.25 (1.29) 20	1.90 (.98) 308	1.92 (1.00) 328
Sit	3.25 (1.03) 20	2.88 (.99) 308	2.90 (1.00) 328

G3: Means and standard deviations for those currently in therapy vs. those not on the state shame scale.

	In therapy M (SD) N	Not in therapy M (SD) N	Total M (SD) N
State shame	41.45 (20.34) 20	29.27 (14.03) 308	30.01 (14.75) 328

G4: Numbers and percentages of participants currently in therapy vs. those not for relationship context (alone, new therapist, old therapist) and experience (Sadness, Dissociation).

	In therapy N (%)	**Not in therapy** N (%)
Relationship Context		
New	11 (9.8%)	101 (90.2%)
Old	4 (3.5%)	110 (96.5%)
Alone	5 (4.9%)	97 (95.1%)
Experience		
Dissociation	10 (6.1%)	154 (93.9%)
Sadness	10 (6.1%)	154 (93.9%)

G5: Means and standard deviations for those who have ever attended therapy vs. those who have never on 8 single-item emotion ratings.

	Therapy ever M (SD) N	**Therapy never** M (SD) N	**Total** M (SD) N
Emotions			
Anger	1.91 (.90) 85	1.59 (.80) 243	1.68 (.84) 328
Shame	2.32 (.86) 85	2.00 (.94) 243	2.08 (.93) 328
Sad	2.80 (1.01) 85	2.37 (1.05) 243	2.49 (1.06) 328
Surprised	2.61 (1.06) 85	2.34 (1.12) 243	2.41 (1.11) 328

Anxious	2.92 (1.05) 85	2.46 (1.19) 243	2.58 (1.17) 328
Guilty	2.00 (.94) 85	1.76 (.94) 243	1.82 (.94) 328
Proud	1.78 (1.03) 85	1.54 (.86) 243	1.60 (.92) 328
Relaxed/calm	2.11 (1.02) 85	2.00 (1.03) 243	2.03 (1.02) 328

G6: Means and standard deviations for those who have ever attended therapy vs. those who have never on 6 behavioural responses.

	In therapy M (SD) N	**Not in therapy** M (SD) N	**Total** M (SD) N
Behaviours			
Talk	3.12 (.99) 85	2.96 (1.12) 243	3.00 (1.09) 328
Leave	2.30 (.99) 85	2.06 (.97) 242	2.12 (.98) 327
Hide	2.63 (1.03) 85	2.20 (1.00) 243	2.31 (1.03) 328
Distract	2.66 (1.06) 85	2.46 (1.06) 243	2.51 (1.06) 328
Annoyed	2.80 (1.13) 85	2.27 (1.05) 243	2.41 (1.10) 328
Frustrated	2.16 (1.07) 85	1.83 (.96) 243	1.92 (1.00) 328
Sit	3.00 (.90) 85	2.86 (1.03) 243	2.90 (1.00) 328

G7: Means and standard deviations for those who have ever attended therapy vs. those who have never on state shame scale.

	Therapy ever M (SD) N	**Therapy never** M (SD) N	**Total** M (SD) N
State shame	36.21 (15.39) 85	27.78 (13.89) 242	29.97 (14.75) 327

G8: Numbers and percentages of participants who have ever attended therapy vs. those who have never for Relationship Context (alone, new therapist, old therapist) and Experience (Sadness, Dissociation).

	Therapy ever N (%)	**Therapy never** N (%)
Relationship Context		
New	38 (34.2%)	73 (65.8%)
Old	25 (21.9%)	89 (22.3%)
Alone	22 (21.6%)	80 (27.2%)
Experience		
Dissociation	47 (28.7%)	117 (71.3%)
Sadness	38 (23.3%)	125 (76.7%)

G9: Means and standard deviations for those who scored low and high on the single-item shame measure on the 7 shame explanations.

	Low M (SD) N	**High** M (SD) N	**Total** M (SD) N
Exposed	2.29 (1.03) 85	3.03 (.97) 170	2.78 (1.05) 255
Flawed	2.14 (.92) 85	2.97 (.95) 170	2.69 (1.02) 255
Control	2.32 (1.17) 85	3.20 (.91) 170	2.92 (1.09) 255
Isolated	1.85 (1.07) 85	2.73 (1.04) 170	2.43 (1.13) 255
Excluded	1.86 (1.00) 85	2.76 (1.00) 170	2.46 (1.09) 255
Badly	1.91 (1.12) 85	2.82 (1.02) 170	2.51 (1.14) 255
Judged	1.91 (1.03) 85	2.99 (1.04) 170	2.63 (1.15) 255

G10 (Study 2): Numbers and percentages for those who currently have and do not have a close friend across relationship contexts (alone, close friend, doctor) and experience (dissociation, sadness).

	Close friend Yes N (%)	**Close friend No** N (%)
Relationship Context		
Doctor	76 (90.5%)	8 (9.5%)
Close friend	71 (92.2%)	6 (7.8%)
Alone	79 (94%)	5 (6%)
Experience		
Dissociation	110 (94.8%)	6 (5.2%)

Sadness	116 (89.9%)	13 (10.1%)

G11 (Study 2): Numbers and percentages for those who have and do not have a doctor whom they see at least occasionally across relationship contexts (alone, close friend, doctor) and experience (dissociation, sadness).

	Doctor Yes N (%)	**Doctor No** N (%)
Relationship Context		
Doctor	64 (76.2%)	20 (23.8%)
Close friend	66 (85.7%)	11 (14.3%)
Alone	68 (81%)	16 (19%)
Experience		
Dissociation	97 (83.6%)	19 (16.4%)
Sadness	101 (78.3%)	28 (21.7%)

G12 (Study2): Means and standard deviations for those who scored low and high on the single-item shame measure on the 7 shame explanations.

	Low M (SD) N	**High** M (SD) N	**Total** M (SD) N
Exposed	2.65 (.98) 68	3.35 (.85) 106	3.08 (.96) 174
Flawed	2.18 (1.05) 68	3.48 (.98) 106	2.97 (1.19) 174
Control	2.73 (1.25) 68	3.59 (1.08) 106	3.23 (1.21) 174
Isolated	1.65 (1.00) 68	2.62 (1.21) 106	2.24 (1.22) 174
Excluded	1.73 (1.06) 68	2.71 (1.17) 106	2.33 (1.22) 174
Badly	1.71 (.84) 68	2.90 (1.15) 106	2.43 (1.19) 174
Judged	2.04 (.94) 68	3.05 (1.12) 106	2.66 (1.16) 174